**Consumer Notice of Rights and Responsibilities**

**Dignity and Respect**

* You have the right to be treated with consideration, dignity and respect- and the responsibility- to respect the rights, property, and environment of all physicians and other healthcare professionals, employees, and other patients.
* You have the right to access your own treatment records and have the privacy and confidentiality of those records maintained.
* You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational, or religious background.

**Knowledge and Information**

* You have the right to receive information about the organization’s services and practitioners, clinical guidelines, and member’s right and responsibilities.
* You have the right- and the responsibility- to know about and understand your health care and your coverage, including:
* Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
* The names and titles of all health care professions involved in your treatment.
* Your clinical condition and health status.
* Any services and procedures involved in your recommended course of treatment.
* Any continuing health care requirements following your discharge from a provider’s office, hospital, or treatment program.
* How your health plan operates- as stated in your Policy and/ or Certificate.
* The medications prescribed for your- what they are for, how to take them properly and possible side effects.

**Continuous Improvement**

* As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
* Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/ or the members’ rights and responsibilities policies.
* Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
* Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

**Eligible Employee**

**Accountability/ Autonomy**

* As a partner in your own health care, you have the right to refuse treatment- providing you accept responsibility and the consequences of such a decision- and the right to refuse to participate in any medical research projects.
* You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
* You also have the responsibility to:
* If you have PacifiCare Insurance identify yourself as such when receiving behavioral health services.
* Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
* Be on time for all appointments and to notify your provider’s office as far in advance as possible if you need to cancel or reschedule an appointment.
* Receive all non- emergent or urgent health care through your assigned behavioral health provider and obtain preauthorization of service from Managed Care Company, if applicable.
* Notify your behavioral health plan within 48 hours- or as soon as possible- if you are hospitalized or receive emergency care.
* Pay all required co- payments and deductibles at the time you receive behavioral health care services.

You have the right at any and all times to contact a member service associate for assistance issues regarding your behavioral health plan.

It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

If you have any questions or complaints regarding your rights, contact the Member Service Associated with your insurance company.

Patient or Guardian’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_