YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

PATIENTS HAVE THE RIGHT TO:

- Be treated with dignity and respect.
- Fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Expect that their records cannot be released without the patient's permission except in an emergency or if required by law.
- Have an easy to understand explanation of their condition and treatment.
- Know about the different types of treatment available regardless of the cost or insurance coverage.
- Get information about their insurance service's role in the treatment process.
- Information about provider's credentials and training.
- Know the clinical guidelines used in providing and/or managing their care.
- Receive a copy of State Board rules upon request.
- Know about State and Federal laws that relate to their rights and responsibilities.
- Know of their rights and responsibilities in the treatment process.
- Share in the information of their plan of care.

PATIENTS HAVE THE RESPONSIBILITY TO:

- Give providers information so they can deliver the best possible care.
- Let providers know of any change in address, phone, workplace or insurance.
- Let their provider know when the treatment plan no longer works for them.
- Follow their medication plan and tell providers about changes.
- Treat those giving them care with dignity and respect.
- Not take actions that could harm the lives of providers, other members, or insurance employees.
- Keep appointments scheduled at a recommended level of care.
- Keep their appointments and call at least 24 hours in advance if they need to cancel.
- Ask their providers questions about their care, so they can understand their care and their role in that care.
- Let their provider know about problems with paying fees.
- Follow the plans and instructions for their care that is agreed upon by the member and provider.
- Pay co-pays at the time of their appointment.

IN THE EVER CHANGING FIELD OF MEDICAL CARE INSURANCE AND BILLING, POLICIES ARE NECESSARY TO PROTECT AND BENEFIT EVERYONE. PLEASE KEEP US COMPLETELY INFORMED OF ANY CHANGES IN YOUR HEALTH CARE POLICIES.

I, THE UNDERSIGNED, CERTIFY THAT THE INFORMATION FILLED OUT ON THE FRONT OF THIS SHEET IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT SHOULD THERE BE ANY CHANGES THAT NEED TO BE MADE, IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE STAFF.

_____

SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE
(REPRESENTATIVE MUST SHOW LEGAL AUTHORITY TO ACT FOR THE CLIENT)

_____

EFFECTIVE DATE

_____ _____

FLEXMAN CLINIC WITNESS DATE

The FLEXMAN Clinic

Professional Counseling Center

PLEASE PRINT CLEARLY AND FILL OUT FORM ENTIRELY **DATE:**

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	
(CIRCLE) SEX: MALE FEMALE	SOCIAL SECURITY #	DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE #	MAY WE CONTACT YOU & LEAVE A MESSAGE? _____YES _____NO PLEASE INITIAL_____		
CELL PHONE #	MAY WE CONTACT YOU & LEAVE A MESSAGE? _____YES _____NO PLEASE INITIAL_____		
EMAIL			
EMERGENCY CONTACT	RELATIONSHIP TO CLIENT	PHONE #	
PARENT OR GUARDIAN NAME (IF MINOR)	PHONE #		
FAMILY PHYSICIAN	REFERRING PHYSICIAN/ HOW DID YOU HEAR ABOUT US?		
IS CONDITION RELATED TO: _____ EMPLOYMENT _____ AUTO ACCIDENT, STATE:_____ _____OTHER ACCIDENT, _____			

PRIMARY INSURANCE

PRIMARY INSURANCE COMPANY	PRIMARY INSURANCE ID #		
POLICY HOLDER FIRST NAME	MIDDLE INITIAL	POLICY HOLDER LAST NAME	
(CIRCLE) SEX: MALE FEMALE	SOCIAL SECURITY #	DATE OF BIRTH	
CLIENT RELATIONSHIP TO POLICY HOLDER: (CIRCLE) SELF SPOUSE CHILD OTHER:_____	POLICY HOLDER'S EMPLOYER		

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY	PRIMARY INSURANCE ID #		
POLICY HOLDER FIRST NAME	MIDDLE INITIAL	POLICY HOLDER LAST NAME	
(CIRCLE) SEX: MALE FEMALE	SOCIAL SECURITY #	DATE OF BIRTH	
CLIENT RELATIONSHIP TO POLICY HOLDER: (CIRCLE) SELF SPOUSE CHILD OTHER:_____	POLICY HOLDER'S EMPLOYER		

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