

# Therapy House

700 Villa Street - Racine, WI 53403

FAX: (262)619-3263

## **PATIENT RIGHTS AND RESPONSIBILITIES**

### **Rights**

As a patient receiving services for mental illness, developmental disabilities, alcoholism or drug dependency, you have the following rights under Wisconsin Law (SS51.61), (HSS94), and Federal Law (42CFR2).

1. To be notified of your rights.
2. To be assisted in the exercise of your rights.
3. To receive prompt and adequate treatment, rehabilitation and educational services which are appropriate for your condition.
4. To refuse all medication and treatment except in a situation where such medication or treatment is necessary to prevent serious physical harm to self or others, provided that you may refuse such medication or treatment even if such refusal would result in serious physical harm to self or others, if such refusal is based upon my membership in a recognized religious organization and the religious tenets of such organization prohibit such medication and treatment.
5. To be free from unnecessary or excessive medication at any time.
6. To refuse experimental research, psychosurgery and electroconvulsive treatments (Your expressed and informed consent is necessary for such procedures).
7. To the confidentiality of all my treatment records as provided in 42 CFR 2 (Federal Confidentiality Regulations) and Wisconsin law (SS51.30), the right to access to such records after discharge from this facility, the right to see portions of your record during treatment if my provider agrees, and to question the record according to the provisions and limitations of the State Mental Health Act.
8. To not be filmed or taped without your expressed and informed consent.
9. To file a grievance if I feel my rights have been violated.
10. To have access to a copy of the State Mental Health Act and HSS 94 upon request.

### **Responsibilities**

1. Every patient is responsible for providing a complete and accurate medical history and cooperating with the treatment plan and procedures prescribed for his/her care.
2. Every patient is responsible for making it known whether he/she clearly comprehends the contemplated course of action and the things he/she is expected to do.
3. Every patient is responsible for being considerate of the rights of the other patients and office personnel and property.
4. Every patient is responsible for providing accurate and timely information concerning his/her sources of payment and ability to meet financial obligations.
5. Every patient is responsible for providing 24-hour notification of cancellation or rescheduling of appointments and adhering to the terms of the Therapy House Payment Agreement.

I hereby acknowledge that I have received a copy of the above "Patient Rights and Responsibilities," as well as an oral explanation upon receipt of this statement.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Staff Witness: \_\_\_\_\_

