



LIGHTHOUSE
PSYCHIATRY AND BEHAVIORAL HEALTH CLINIC

Patient Rights and Responsibilities

·Patients have the right to:

- Be treated with respect and dignity.
- Have their cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
- Receive quality treatment from trained individuals, regardless of race, creed, sex, or national origin.
- Receive treatment in the least restrictive environment.
- Be informed about their diagnosis, treatment, prognosis, and any recommended treatments in terms that they can understand.
- Make informed decisions regarding their treatment.
- Refuse treatment.
- Receive treatment in an environment that is safe and secure.
- Privacy and confidentiality.
- Access information contained in their medical record, according to federal privacy laws, unless clinically contraindicated.
- Be informed of any rules and regulations governing Lighthouse Psychiatry & Behavioral Health Clinic which affect them.
- Access the Quality Improvement Officer to voice and receive aid in resolving concerns, conflicts, grievances, and/or complaints.
- File a complaint with the appropriate state regulatory agency.

· Patients are responsible to:

- Inform their provider to the best of their knowledge, complete and accurate information regarding their medical history, including present symptoms, past illnesses, medications, both prescription and non- prescription, hospitalizations, etc., and to report any changes in their health or in the medication they take.
- Accept consequences should they refuse treatment or not follow the recommendations of the treating professional.
- Ask questions of their provider, or as applicable, Lighthouse Psychiatry & Behavioral Health Clinic staff when they are unclear about any aspect of their treatment.
- Be considerate of the rights of, and treat respectfully, other patients and staff.
- Take an active part in planning, implementing, and following through with their treatment program.

- Provide adequate notice in the event they are unable to attend a scheduled appointment.
- Notify their network provider if they choose to discontinue their treatment.
- Follow the rules of the program in which they are participating.
- Meet financial commitments agreed to with their network provider.
- Protect the confidentiality of other patients by not disclosing their names or any other information disclosed by other patients.

ACKNOWLEDGEMENT OF RECEIPT

Your signature acknowledges that you have received a copy of the Patient Rights & Responsibilities.

Patient Name: _____

Patient Signature or Patient Representative: _____

Date Signed: _____