VALDOSTA PSYCHIATRIC ASSOCIATES, LLC

PATIENT BILL OF RIGHTS

Patient Rights
I have he right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited for me. We will use this plan to help us deal with my problems as quickly and effectively as possible. I have the right to refuse treatment or discontinue treatment.

I have the right to be treated with dignity and respect. I will be treated with respect at all times. I will report any misconduct by my treatment provider including social invitations, suggestive remarks or unwanted touching to the appropriate state agency. I will report any complaints regarding the clerical staff to my doctor/therapist or office manager.

My treatment provider will make every effort to meet with me at our scheduled appointment time. If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.

I have the right to privacy and confidentiality. All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my treatment provider to report suspected abuse, neglect, or domestic violence and those who pose a danger to themselves or others.

Patient Responsibilities
Scheduled appointments are commitments. I will make every effort to be on time for my appointments. If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my provider at least 24 hours in advance, I understand I may be charged a missed appointment fee.

I am responsible to pay for services received. I am aware my insurance plan typically requires me to pay a co-pay or percentage of my treatment fee at the time services are provided. My insurance plan may also have a deductible that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand I am financially responsible for all co-pays, co-insurance amounts, deductibles and all services not covered by my insurance plan. My provider, the office staff, and my insurance plan's representative will help me determine what services my plan covers.

My health is my responsibility. I will contact my treatment provider for any serious situation that arises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my provider of any changes in my condition.

I have read or had read to me the above list of Rights and Responsibilities.
I understand them and agree to them.

Patient Name:_____ Date:_____

Date of Birth:_____ Social Security Number:_____

_____ _____

Signature of Patient or Guardian Relationship Signature of VPA staff