DARING MINDS
therapy

2001 Pine Lake Road
Suite 200
Lincoln, NE 68512

www.daringmindstherapy.com
Info@daringmindstherapy.com

p. (531) 289-1005
f. (531) 289-1002

Sarah Worley, LIMHP, LADC, CPC
Erica Schroeder, PLMHP, PLADC
Stephanie Orr, LIMHP, LADC
Maureen Deryke, PLCSW

Client Rights and Responsibilities / No Show Policy

As a client of Daring Minds Therapy, you are entitled to all legal and civil rights granted by Federal and State Constitutions and Laws. In addition, **persons served have the right**:

- to be free of physical and sexual abuse, harassment, neglect, and physical punishment; psychological abuse, including humiliation, threats, exploitation and retaliation; fiduciary (financial) abuse
- to be informed prior to or at the time of admission of charges for care, treatment, or related charges;
- to be treated with dignity and respect;
- to receive prompt and professional services;
- to know the credentials and training of the persons providing services;
- to reasonable accommodations for disabilities;
- to expect staff to abide by client confidentiality and privacy regulations and to receive a copy of the Privacy Practices at Daring Minds Therapy;
- to a timely review of information contained in the clinical record in order to facilitate decision-making. Requests can be made verbally or in writing to the Clinical Director or their designee who will respond within 5 working days of the request;
- receive accurate information concerning diagnosis, treatment, risks, and prognosis of your mental health condition;
- to participate actively in decisions regarding one's healthcare and treatment;
- revoke your authorization to release except to the extent that action has already been taken
- to request a written explanation within ten (10) working days, and to expect a written response within five (5) working days, if you are refused services while in treatment;
- to voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed;
- to file a complaint or grievance with the State Department of Health and Human Services, Division of Public Health, Investigations, 10033 "O" St, Lincoln, NE 68508, 402-471-0175;
- Patients under 19 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records;
- Our office is required to maintain records for seven years following the discontinuation of services;
- According to 42 CFR Part 2, substance use records cannot be released without written consent of the client or without a signed judge's order, this also applies to minors.

Client Responsibilities

As our client, **your responsibilities** include the following:

- to uphold the terms of the financial agreement; pay for all services not covered by a third party including payment for any no show or missed appointment;
- to submit a breathalyzer upon request;
- to authorize the program to secure medical services in the event of medical emergency;
- to pay for any damage deemed to be intentionally inflicted upon agency staff or other client's property;
- to follow the rules and program established for your treatment;
- give 24 hours notice if you cannot attend an appointment or be subject to a $50 fee if a no-show or late cancellation of appointment occurs.

Rules for all programs include, but are not limited to, the following:

- Possession or use of drugs or paraphernalia on Daring Minds Therapy property and/or at Daring Minds Therapy supervised activities is not allowed;
- Possession of weapons including guns and knives on Daring Minds Therapy property and/or at Daring Minds Therapy supervised activities is not allowed;
- Physical or verbal violence or threats of violence will not be tolerated;
- Sexual contact or harassment on the premises is not allowed;
- Respect the rights of other clients, including the right to confidentiality.

AGREEMENT AND RELEASE

The undersigned hereby acknowledges having read, understood, and received a copy of this Client Rights and Responsibilities, and agrees to meet those responsibilities.

The undersigned also agrees to release and hold harmless Daring Minds Therapy, its agents and employees, from any and all liability for injuries sustained by me while on the premises or participating in any program or activity of Daring Minds Therapy, or resulting from any actions of Daring Minds Therapy, its agents or employees.

I understand that my violation of this agreement or the program's rules may result in my discharge from the program or other disciplinary action.

Client Signature _____ Date _____

Parent or
Legal Guardian
Signature _____Date_____

Witness_____ Date_____