**Patient Bill of Rights**

* To receive quality medical, behavioral and mental health services regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
* To seek a consultation with the physician(s) or provider of choice.
* To be treated with respect by Touchstone Health Clinic.
* To information contained in your medical record (except when exempt under State and Federal Law).
* To have a right to participate in decisions involving your health care.
* To use your own resources to purchase the care of your choice (based on medical necessity).
* To refuse medical treatment even if it is recommended by their physician(s) or provider.
* To personal privacy. Any discussion consultation, examination and/or treatment regarding your care will be done discreetly.
* To confidentiality of your medical record and other information related to your medical condition.
* To be informed about your medical or mental health condition, the risks and benefits of treatment and appropriate alternatives.
* To receive full disclosure of your insurance plan in plain language (to the best of our abilities).
* To be seen in a safe and clean environment.
* To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved.

**Patient Responsibilities**

* To **provide**, to the best of your knowledge, **complete information** about your symptoms, past illness and medical history, medications and other matters relating to your health.
* To schedule and **keep your appointments**, or to call to cancel your appointments in a timely fashion.
* To **arrive on time**, if you do not arrive on time, you acknowledge that your appointment time may be cut short, and/or your appointment may have to be rescheduled.
* To **notify the clinic of any demographic changes**, including but not limited to, changes in insurance coverage, address, and phone number.
* To **ask questions** when you do not understand explanations about your care or services.
* To **be responsible** for your actions, if you refuse treatment or do not follow your providers instructions.
* To follow the organization policies.
* To be **courteous** and **considerate** of Touchstone Health Clinic’s staff, providers, interns and other clients; please be aware that **aggressive, abusive, or threating behavior towards staff, providers, interns and/or other clients by clients and/or their representative, will not be tolerated.**
* To understand your insurance plan and agreement with your insurance company regarding your financial responsibility for services provided.
* **Failure to follow patient responsibilities** may result in a formal discharge from services rendered at Touchstone Health Clinic.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_