



# CLIENT RIGHTS CHECKLIST

Client/Legal Guardian, Please initial on each applicable line. If not applicable, please put NA.

\_\_\_\_\_ I hereby acknowledge receipt of the following information:

- List of my rights as a client of Pawnee
- List of my responsibilities as a client
- Description of Pawnee services.
- Information about HIV (for alcohol/drug services only)
- How to obtain services during regular hours of operation
- How to obtain services after-hours or in an emergency
- Information about confidentiality practices and exceptions.
- Copy of Notice of Privacy Practices
- Information about billing and payment
- Information regarding fees and co-payments
- Information about treatment of minors
- Process for submitting a complaints or suggestion
- Information about satisfaction surveys

### Consent for Treatment of a Minor:

\_\_\_\_\_ As legal guardian of \_\_\_\_\_ I authorize and give legal consent to treatment at Pawnee Mental Health Services.

### Informed Consent:

\_\_\_\_\_ I acknowledge that I have been informed that the professional with whom I am initiating treatment holds the following degree: MD. Ph.D. LMLP LCSW Other \_\_\_\_\_

\_\_\_\_\_ I understand and accept that my treatment at Pawnee Mental Health Services is being provided by a student intern who is completing a requirement for a Master's Degree in Psychology or Social Work. I have been informed that my therapist's clinical work is being supervised by:

Name, Degree and License \_\_\_\_\_

### Primary Care Physician Collaboration: Initial Only One

\_\_\_\_\_ I do **NOT** want my primary care physician contacted by Pawnee Mental Health Services for the purpose of continuity in my health and mental health care.

\_\_\_\_\_ I **DO** want my primary care physician contacted by Pawnee Mental Health Services for the purpose of continuity in my health and mental health care. **Separate Authorization Required.**

### Payment Authorization:

\_\_\_\_\_ I hereby authorize Pawnee Mental Health to disclose diagnosis, dates of service, and type of service as well as any other additional information required by my insurance carrier to process insurance claims for payment. I further authorize the payment of insurance benefits directly to Pawnee Mental Health Services for services provided.

\_\_\_\_\_  
Client Signature/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

I.D. Number: \_\_\_\_\_

031-ADM-05/04