

## CLIENT'S RIGHTS

I understand that as a client of NUIHC, I have the right to:

- Refuse or not to participate in particular type of therapy while in treatment or to terminate treatment at any time with the understanding that by exercising this right legal or other consequences of my action may occur.
- A safe environment, free from physical, sexual, and emotional abuse.
- Plan my treatment including goal setting, methods used, potential risks and benefits, and the progress.
- Written information about fees payment methods, co-payments, length and duration of sessions and treatment.
- Know the limits of confidentiality, the situations in which the clinician or agency is legally required to disclose information about my case to outside agencies, and the types of information which must be disclosed unless restricted under Ne. revised statute 83-1068.
- Know that my case will be discussed with supervisors and /or peers, but that no portion of my therapy will be recorded in audio or video form without my informed written consent; and that if I consent to have any portion of my therapy recorded, I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed.
- Request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status.
- Request the release of my clinical information to any agency or person I choose or the right to refuse authorization to disclose information.
- Exercise my rights as a customer of this agency and the same as a citizen of the United States.
- Be free of arbitrary transfer or discharge from this program.
- Voice my complaints and file grievances without discrimination or reprisal and to have my complaints and grievances addressed as outlined in the program grievance procedure.
- Examine the results of the most recent survey of the facility conducted by representatives of the Department of Health and Human Services.
- Be free of restraints and/or seclusion in a locked room except when provided in 175 NAC 19-006.14 and/or in case of civil protective custody.
- Inspect and receive a copy of your medical record.
- Request a restriction on certain uses & disclosures of your health information
- Request a correction/amendment to your medical record if you believe that health information we have about you is incorrect or incomplete, we may amend your record or include your statement of disagreement.
- Request confidential communications about your health information. You may request that we communicate with you at a location other than your home or by a different means of communication such as telephone or mail

- Receive a listing of certain disclosures the agency has made of your health information upon request. This information is maintained for 5 years or the life of a record, whichever is longer.
- Revoke your written authorization to use or disclose health information. This does not apply to health information already disclosed or used in circumstances where the agency has taken action in reliance on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.
- Be informed about the professional capabilities and limitation of clinician(s) involved in my therapy, including their certification/ licensure, education and training, experience specialization, and supervision; and to be treated only by persons who are trained and qualified to provide the treatment I contract to receive; and to be informed of the credentials of the program personnel which are as follows:

- a. **Barry Walker, BS, LADC, Director of Residential Treatment**
- b. **Loretta Jordan, BA, LADC #680, Clinical Supervisor**
- c. **Vince E. Maytubby, MA, PLMHP #8486, LADC#841, Inpatient Therapist**

By signing this information of my client's rights, I acknowledge I have received a copy of this form

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date