ACAPS
Appalachian Counseling and Psychological Services, Inc.

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www.apppsych.org

Patient Rights & Consent to Treatment

By signing below, I am consenting to receive services from Appalachian Counseling and Psychological Services, Inc., (hereafter referred to as ACAPS). I understand that I may revoke this consent at any time by **submitting a written request**. Additionally, I understand that I have certain rights, which include, but are not limited to, the following:

- I understand that in order to sign this form I must have legal guardianship and/or be the legally responsible person of myself or the patient who is receiving services.
- I have the right to participate in the development of a treatment plan (if receiving therapy services). Additionally, I may request a copy of this treatment plan through my provider.
- I have the right to dignity, privacy, humane care and freedom from physical punishment, abuse, neglect, and exploitation.
- I have the right to be connected to and receive appropriate physical, behavioral, and/or emotional healthcare regardless of the type and degree of disability I have.
- I have the right to contact the Disability Rights of NC Office (Ph. 877-235-4210) to file a complaint if I feel my rights have been violated and have been unable to resolve the issue by communicating with staff of ACAPS.
- I understand that ACAPS is a Mandated Reporter.
- I have the right for privileged information to be kept confidential, except in the following situations:
  - Under order of a subpoena and/or court order
  - If a child or disabled adult is suspected of being abused or neglected
  - If I am a risk of harm to myself or others
- I understand that release/disclosure of my information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.
- I understand that I am granting permission to seek emergency medical care from a hospital or physician.
- I have the right to refuse services.
- I understand that any treatment, including psychological testing, carries certain risks. I further understand that I will need to address any concerns that I may have with my ACAPS provider prior to the beginning of treatment.

Patient/Legal Guardian Signature	Date	ACAPS Staff/Witness Signature	Date

Provide Relationship to Patient if Guardian