

PATIENTS RIGHTS/GRIEVANCE/DISCHARGE POLICIES

As a Client of AMERICAN PSYCHIATRIC GROUP, Inc. you have the right to:

- Receive appropriate humane treatment, which minimizes restriction of your personal liberty only to the extent necessary for your treatment needs, and applicable legal requirements.
- Be protected from harm and to be free from mental, physical, and sexual abuse while receiving treatment.
- An Individual Rehabilitation Plan (IRP)/Individual Treatment Plan (ITP).
- Participate in a manner appropriate to my condition, in the development and periodic review of your treatment plan.
- Receive treatment as stated in your IRP/ITP.
- Be told in appropriate terms and language of:
 - -The contents and objectives of treatment or rehabilitation.
 - -The nature and significant possible negative effects of treatment or rehabilitation.
- The name, title and role of staff members who are directly involved in your treatment, and when appropriate, the names of other treatment providers and their services.
- Access my treatment records and the right, with written permission, for your attorney or others designated by you, to have access to your records.
- In the event your treatment provider believes that it would be harmful to you to read your records, you have the right to a written summary of those sections of the record your treatment provider believes might be harmful.
- Refuse medication.
- Refuse to participate in physically intrusive research.
- Prior to admission, to an explanation in terms and language that you can understand of admission and discharge policies.
- Prior to admission, to an explanation of your rights in terms and language that you can understand, and to have a list of your rights posted in a prominent place in the facility.
- Prior to admission, to an explanation in terms and language that you can understand, of the charges and fees that you will be required to pay.
- An After Care Plan.
- File a grievance if you are not satisfied with the treatment that you receive

GRIEVANCE POLICY

American Psychiatric Group, Inc. maintains a firm commitment to the provision of quality care to children, adolescents, adults, and the families it services. An integral support in implementing this philosophy is the provision of a mechanism for receiving and responding to complaints from individuals in our program. The proposed process is as follows:

At time of admission, client referring party and parent/guardian will be informed, both verbally and in writing about the mechanism for expressing any complaints. Their right to initiate the grievance procedure and the review of the complaint concerning quality of care will be discussed, and they will be assured that in no way will the client service be compromised should the individual, guardian, family member or referring party choose to use this process.

1. In the event you have a grievance, you may personally, through or in combination with other persons, present grievances and recommend changes in policies and services on behalf of yourself or others without fear of reprisal, interference, coercion, or discrimination.

2. A grievance may be initiated verbally but must be confirmed in writing or by tape recording to the program director.
3. The Program Director will review the report and respond in writing.
4. The Program Director will forward the grievance to the appropriate persons or committee.
5. All of the above steps will be completed within 14 days.
6. If appropriate, the written response will include an assessment of any factors contributing to the grievance, and proposed remedies, if any to prevent a reoccurrence of problems.
7. If you are not satisfied with the outcome of this internal process, you may forward your grievance to the Baltimore City Core Service Agency- Baltimore Mental Health Systems, Inc. (410) 837-2647 and/or Maryland Disability Law Center (410) 727-6352.

I have been informed of the policies and procedures for submitting a grievance. I understand the policies and procedures as explained to me. If there is any portion of the procedures that require further explanation, I understand that I am free to request an explanation and assistance now or in the future.

HIPAA / CONFIDENTIALITY NOTICE TO OUR PATIENTS

Under the Federal Health Insurance Portability and Accountability Act (HIPAA-passed in 1996) offices like ours were required to create practices patient's health information (PHI) by April of 2003.

We want our patients to understand how we protect their privacy when we collect and use health information and the measures, we take to safeguard that information. Each of these instances is spelled out in our Privacy notice. We do not disclose any information about a patient or former patient to anyone, except as permitted by law.

This notice also lists your rights under HIPPA:

- The right to access your PHI
- The right to amend your PHI
- The right to an accounting of disclosures by the health plan
- The right to request restrictions on the use and disclosure of your PHI
- The right to receive confidential communication

Please read our Privacy Policy Notice available in our waiting area which includes information regarding your rights under HIPAA.

The confidentiality of mental health and alcohol/drug abuse patient records are maintained by this program and are protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client UNLESS:

- The Client consents in writing;
- The disclosure is allowed by a court order, or
- The disclosure is made to medical personnel in a medical emergency
- To qualified personnel for research, audit or program evaluation.
- Right to protect in case of threats of homicide or suicide
- Right to report elderly or child abuse or neglect

Violation of the Federal laws and regulations by a program is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations. Federal laws and regulations do not protect any

information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child or elderly abuse or neglect from being reported under State law to appropriate State or local authorities. I understand that my records are protected under Federal Confidentiality regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations) published August 10, 1987, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions

I have read and understood this notice and require no further information at this time.

DISCHARGE PROCEDURE

All of the services provided by American Psychiatric Group, Inc. are on a voluntary basis. Our Staff is committed to providing quality care. In order to do so, it is essential that you, the client, understand our policy for termination of services when they are no longer needed or required. Our conditions are listed below:

1. Termination of services shall, whenever possible, be a collaborative effort between you and your therapist. When this decision is made, your therapist will develop, with you, a discharge plan formulating your needs and assist you with necessary referrals for treatment, rehabilitation, or community support.
2. You will be discharged from services after missing three (3) appointments in 60 days and have made no indication of your desire to return. Staff will make reasonable attempts to re-engage you. We will also send a written notice informing you of your discharge before terminating services.
3. A decision to terminate services may be recommended if you fail to comply with treatment goals. These treatment goals are mutually agreed upon between you and your worker.
4. If you are not able to attend treatment due to hospitalization or other temporary reasons, your chart will remain in open status until you are able to return to treatment, or you choose to discontinue services.
5. You may discontinue services at any time. You should discuss it with your therapist if you choose to do so.
6. **Your treatment may be terminated if you present a threat to the health or safety of the clinic staff.**

In order to assure that you understand our policy for termination, we ask that you sign and date this form. A copy will be given to you at admission to the program and a copy will remain in your record.

I have been given a copy of the Patients' Rights Policy, Grievance Process and Discharge Policy for my review and will have access to all signed documents through the Client Portal of APG's Electronic Health Record System.

CLIENT RESPONSIBILITIES

I understand that time is allocated for my attendance and that if I am not able to attend on the day/time of my appointment and/or within the agreed upon timeframe, I will provide at least 24 hours' notice of cancellation.

TRANSFER, REFERRAL, OR SERVICE INTERRUPTION

In the event that the staff with whom I have been working leaves the practice, as much notice as possible regarding said change will be provided. I may also notify the agency should I decide I wish to change providers. In either case, options for transfer within the agency, transfer outside of the agency, and other referrals will be made available based on the client's needs and preferences.



RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize the American Psychiatric Group staff to apply for payment from my insurer for services provided, understanding that the release of some protected information will be necessary. I authorize payment directly to the American Psychiatric Group. I permit a copy of this authorization to be used in place of the original and it may be retained on file.

REVOCATION OF CONSENT

I have been given a copy of the Patients' Rights Policy, Grievance Process and Discharge Policy for my review and will have access to all signed documents through the Client Portal of APG's Electronic Health Record System.

Client Signature: _____ Date: _____