

Client Rights & Responsibilities

As a client receiving psychological and/or neuropsychological services, you have the following rights and responsibilities:

Client Rights

- You have the right to receive respectful, confidential, and professional psychological and neuropsychological services.
- You have the right to receive clear information about the nature of services, risks, benefits, and alternatives before consenting.
- You have the right to be informed about evaluation findings, diagnoses (when applicable), treatment options, risks, and expected outcomes.
- You have the right to receive information about telehealth services, including risks, benefits, alternatives, and privacy protections.
- You have the right to participate actively in your evaluation and/or treatment planning and to ask questions at any time.
- You have the right to refuse or discontinue evaluation and/or treatment, with an explanation of possible consequences when clinically relevant.
- You have the right to privacy and confidentiality, within the limits of the applicable law (e.g., mandated reporting, court orders).
- You have the right to timely access to care and to be informed promptly of scheduling changes as soon as possible.
- You have the right to be informed of any significant changes in services, policies, or provider availability that may affect care.
- You have the right to receive services free from discrimination based on race, color, national origin, sex, gender identity, sexual orientation, religion, age, disability, or other protected status. Language assistance and reasonable accommodations will be provided consistent with federal civil rights requirements.
- You have the right to have your questions and concerns addressed promptly and respectfully.
- You have the right to receive clear information about fees, billing practices, and financial policies. If you are uninsured or self-pay, you have the right to receive a Good Faith Estimate of expected charges in accordance with the No Surprises Act.
- You have the right to inspect, review, and request copies of clinical records in accordance with applicable federal and Florida law.
- You have the right to request restrictions on certain disclosures, request confidential communications, and receive an accounting of disclosures in accordance with HIPAA.
- You have the right to a safe and supportive environment during evaluation and/or treatment services.
- You have the right to report complaints or concerns without fear of retaliation. You have the right to file a formal complaint with the practice and to receive information about external complaint processes, including the Florida Board of Psychology and the U.S. Department of Health and Human Services Office for Civil Rights.
- You have the right to receive care that respects cultural, linguistic, religious, developmental, and family values.
- You have the right to know the credentials, licensure status, and professional role of your provider.

Client Responsibilities

For minor patients, parents or legal representatives are responsible for compliance with consent, custody, and legal authority requirements.

- You agree to attend scheduled appointments on time and provide advance notice if you need to cancel or reschedule.
- You agree to provide accurate and complete information to support effective evaluation and/or treatment.
- You agree to participate actively in services and follow mutually agreed-upon recommendations to the extent possible.
- You agree to respect professional boundaries and office policies.
- You agree to inform your provider of changes in health, medications, or circumstances that may affect evaluation and/or treatment services.
- You agree to meet financial obligations as outlined in the practice's fee and payment policies.
- You agree to communicate concerns about care in a timely manner.
- You agree to respect the privacy and confidentiality of other clients and office matters.
- This practice does not provide emergency or crisis services. In the event of an emergency, call 911, go to the nearest emergency department, or contact appropriate crisis resources.
- Clients are expected to communicate respectfully with clinicians and staff. The safety of patients, families, clinicians, and staff is a priority. Threatening, abusive, or unsafe behavior may result in modification, suspension, or termination of services consistent with ethical, clinical, and legal standards.

If you have any questions or concerns about your rights or responsibilities, please ask at any time. Your comfort and understanding are important to us.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Acknowledgment of Receipt and Review (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have read and understand the Client Rights & Responsibilities of Pediatric Neuropsychology Associates PLLC. I understand that this document is provided for informational purposes and does not require my consent for services.

By signing below, I confirm that I am the parent or legal representative of the patient named below and that I have the legal authority to receive and acknowledge this information on the patient's behalf.

I understand that I am not required to sign this acknowledgment. If I choose not to sign, the practice will document that the document was provided to me.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

A copy of this signed form will be retained in the patient's health records.

For Office Use Only

Date Received: Received By:

Staff Role:

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: