I understand I have the right to:

- be treated with dignity, respect, and consideration at all times. I will not be subject to humiliation, abuse and/or neglect of any form. I understand that Dilworth Center does not use seclusions or restraining devices. Emergency interventions using EBPI techniques will be used in response to assault, aggression, and threatening and/or violent behavior.
- services that are responsive to age, gender, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation, spiritual beliefs, genetics, medical history, race, ethnicity, nationality, mental or physical disabilities and will not be denied services based solely on these issues.
- obtain from staff the complete information concerning my diagnosis, treatment, and/or prognosis in terms I can reasonably be expected to understand.
- be assigned an individual counselor responsible for my care and will be informed of the composition of the clinical team.
- receive sufficient information necessary to give informed consent prior to the start of any treatment procedure, as well as the treatment team composition.
- refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
- privacy and to be free from any search of my person or property without just cause.
- have my presence in treatment and all records pertaining to my care protected under federal and state law.
- confidentiality and informed consent to release any such information.
- be involved in all aspects of my care and services, including participating in the formulation of my individualized treatment plan, and review of this plan on a regular basis.
- access the most appropriate, least restrictive level of treatment based upon my needs and best interest.
- participate in activities designed to enhance my self-esteem and support, including mutual help.
- quality services suited to my needs, administered skillfully, safely, humanely, and with full respect for my dignity and personal integrity.
- communicate freely and privately with other persons, within the guidelines of the program policies.
- be informed of the program rules and expectations for patient behavior.
- be fully informed of the services, including the cost of those services. I have the right to examine and receive an explanation of my bill and be free from financial exploitation.

- request to see my record, except in some situations described by law.
- continuity of care, including the right to know in advance any appointment times and when clinical staff are available, and the right to be informed of my continuing care needs following discharge.
- expect a reasonable response to my request for services, within the program's capabilities and responsibilities, with access to information within sufficient time to facilitate my decision making.
- be informed of the relationship of this program to other healthcare and educational institutions as related to my care.
- be informed of any research projects or experimentation affecting my care, and I have the right to refuse to participate.
- access legal counsel, at my expense, within the structure and schedule of the program, as well as standard legal rights.
- members of my family having the same rights to consideration, respect, informed consent and confidentiality regarding treatment service records that I have as a patient.
- a copy of my discharge plan that contains recommendations about other services I may need.
- file a grievance if I believe that my rights as a patient have been violated and to expect a prompt and appropriate response to that grievance. I have the right to be informed of the procedure of filing such a grievance and I will not be retaliated against for filing a grievance. I understand that my counselor and the Clinical Supervisor have been identified as my patient advocates. They will assist me in the grievance process, if I would like assistance. They can be reached at 704-372-6969.

My rights as a patient have been fully explained to me. I understand that if I have any questions, I may ask any staff member for further explanation.

________________________________ ________________

Patient Signature Date

________________________________ ________________

DC Staff Witness Date