Beautiful Mind Therapy, Inc
Phone: 708-695-4808 Fax: 888-965-7017
975 East Nerge Road, Suite W40, Roselle, IL 60172-4809

Notice of Client Rights

I do not discriminate against any client's age, sex, gender, marital status, race, religious beliefs, ethic origins, ancestry, disability, health, military discharge, or sexual orientation.

You have the following client rights:

1. Right to request how I contact you. Regarding health matters, such as appointment reminders etc., I will communicate with you at your home address and at the daytime phone number you give me when you schedule your first appointment. Sometimes I may leave voicemail. You have the right to request that I communicate with you in a different way.

May I contact you at home (circle one)?	Yes No	Phone Number: _____
May I contact you at work (circle one)?	Yes No	Phone Number: _____
May I contact you by cell phone (circle one) ?	Yes No	Phone Number: _____

Where may I contact you ?_____ Where may I leave a voicemail? _____

2. Right to release your medical records. You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I acted in reliance on such authorization.

3. Right to inspect and get copies of your medical and billing records.: You have the right, with limited exceptions, to review or obtain copies of your medical records. Your request must be made in writing. You will receive a response from me within 60 days of my receiving your written request. If I deny your request, I will provide you a written explanation and will tell you if the reasons for the denial can be reviewed, how to ask for such a review, or whether the denial cannot be reviewed. If you request a copy of your medical records, I will charge you $ 0.50 per page.

4. Right to amendment. You have the right, with limited exceptions, to request that I amend your medical record. Your request must be made in writing, and it must explain why the information should be amended. You will receive a response within 60 days of my receipt of your request. I may deny your request if I did not create the information you want amended and the originator of that information remains available, or for certain other reasons. If I deny your request, I will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If I accept your request to amend the information, I will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

5. Right to an accounting disclosure. As of April 1, 2014, you have the right to receive a list of instances in which I or my business associates disclosed your medical records for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities. After April 1, 2014, disclosure records will be held for six years. You must submit your request in writing. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, to whom the medical records were disclosed, a description of the information disclosed, and the reason for disclosure. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests. I will provide you with more information on my fee structure at your request.

6. Right to request restrictions. You have the right to request that I place additional restrictions on my disclosure of your medical records. Any agreement I may make to a request for additional restrictions must be in writing and must be signed by you or a person authorized to make such an agreement on your behalf. I will not be bound unless our agreement is in writing. While I will consider your request, I am not legally bound to agree. If I do agree to these additional restrictions, I will abide by our agreement (except in emergency situations). You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

7. Right to complain. If you believe your privacy rights have been violated, please contact me to discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, 877-696-6775, http://www.hhs.gov or Professional Counselor Licensing and Disciplinary Board, 320 W. Washington Street, Springfield, IL 62786, 217-785-0800, www.idfpr.com/dpr/who/prfcns.asp. An individual will not be retaliated against for filing such a complaint.

8. Right to receive a copy of the notice. You may request a copy of this notice and any amended notice at any time. If you receive a notice on my website or by electronic mail (email), you are also entitled to request a paper copy of the notice.

By signing below, I acknowledge that I have received the Notice of Client Rights.

Patient Name: _____ Patient Signature: _____ Date: _____
(age 18 and older)

Patient Name: _____ Patient Signature: _____ Date: _____
(age 12 and older)

Parent/Guardian name:_____ Patient Signature: _____ Date: _____
(for client under age of 18)

Therapist Name: _____ Therapist Signature: _____ Date: _____

It is your right to refuse to sign this document.