CLIENT:

RECORD NUMBER:

1. Client to read, initial each section, and sign and date form.
2. Parent to initial each section and sign if client is minor.
3. CHC Staff will answer questions.

**As a client of Coastal Horizons Center, Inc., or as the guardian of such a client, you are assured of certain rights. Among these rights is the right:**

**1.** To dignity, respect, humane care, and freedom from mental, emotional, sexual and physical abuse, neglect and exploitation. You also have the right to receive treatment that is culturally sensitive to you, including sensitivity to social, psychological, physical, and spiritual factors.

**2.** To treatment, including access to medical care and habilitation, regardless of age, sex, religion, national origin, degree of mental illness, mental retardation, substance abuse, and to:

**a.** Participate in the development of your individualized written service plan developed within 30 days from admission.

**b.** Receive information on potential risks and possible benefits of treatment choices, to refuse any treatment offered, and to terminate treatment - unless you have been court-ordered to attend.

**c.** Not be excessively or unnecessarily medicated, and to have medication ordered and prescribed only by a physician with documentation of such prescriptions in your client record and in accordance with accepted medical standards.

**d.** Confidentiality as explained in the client handbook and in compliance with state and federal laws.

**e.** Not be physically restrained or subjected to search and seizure by any Coastal Horizons Center employee.

**3.** To live as normally as possible while receiving care and treatment/habilitation.

**4.** To refuse to be finger printed, audio-taped, video-tape or photographed unless you or your guardian gives consent.

**5.** To never have corporal punishment at a Coastal Horizons Center facility.

**6.** To pursue any grievances using the Client Grievance Procedure posted on the public bulletin board and in the OTS Client Handbook, or to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD) at 1-800-821-6922.

**7.** To consult with legal counsel or private physicians of your own choice at your own expense.

**8.** To protected privacy of your health information as stated in the Agency Privacy Notice.

**9.** To timely access to information pertaining to you, including your medical record, to assist you in decision-making.

I have been informed of these rights. ______________________**(Client/Parent initials)**

**A. <u>REQUEST FOR TREATMENT</u>**

I do hereby request outpatient treatment for either a substance use and/or mental health disorder from Coastal Horizons Center, Inc. and voluntarily give consent for treatment according to my individualized treatment/case management plan. [GS 122C-57] I understand that **I (**or those others that I have designated in writing by completing an Authorization For Use and Disclosure of Protected Health Information form) may be contacted by staff on a follow-up basis after I have discontinued my involvement with this agency.

______________________**(Client/Parent initials)**

**B. <u>EMERGENCY MEDICAL CARE</u>**

In the event that I might need emergency medical care while attending Coastal Horizons Center, I give permission for the qualified agency staff to 1) administer emergency care to me & 2) contact 911 for additional medical care. A separate written Authorization for Use and Disclosure of Protected Health Information must be completed to notify family, friends, significant other(s) or primary physician.

______________________**(Client/Parent initials)**

**C. <u>PROGRAM AUTHORITY / UNDERCOVER AGENTS & INFORMANTS</u>**

Coastal Horizons Center, Inc. may not knowingly employ, or enroll as a client, any undercover agent or informant. [42 CFR Part 2, 2.17 a] Therefore, Coastal Horizons Center, Inc. will deny admission or terminate treatment services for any individual known to be an undercover agent or informant.

I have been informed of this notice: ______________________**(Client/Parent initials)**

**D.** I have received a copy of the OTS Client Handout, and now understand and agree to abide by the rules & regulations of the program including all of the above.

______________________________ ______________________________

**Signature of Client/Date** **Signature of CHC Staff/Date**

______________________________

**Signature of Parent/Guardian/Date (Optional)**