



Project Point of Light

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**CLIENT’S RIGHTS**

- \*Be treated with dignity and respect.
- \*Fair treatment; regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- \*Have treatment and other patient information kept private. Only when permitted by law, may records be released without patient’s permission.
- \*Easily access timely care.
- \*Know about their treatment choices, regardless of cost or coverage by their benefit plan.
- \*Share in developing their care plan.
- \*Given information in a language they can understand and provided with a clear explanation of their condition and treatment options.
- \*Given information about their insurance coverage, its practitioners, services and role in treatment.
- \*Provided information about clinical guidelines used in providing and managing their care.
- \*Ask their provider about their work history and training and be able to request certain preferences in a provider.
- \*Given information about advocacy and community groups and prevention services.
- \*Freely file a complaint or appeal and be provided the information on how to do so.
- \*Know their rights and responsibilities in the treatment process.
- \*Receive services that will not jeopardize their employment.
- \*Have provider decisions made about their care without regard to financial incentives.

**CLIENT’S RESPONSIBILITIES**

- \*Treat those giving them care with dignity and respect.
- \*Give providers information they need to deliver the best possible care.
- \*Ask questions about their care to assist in understanding their care.
- \*Follow the treatment plan and agreed upon medication plan.
- \*Tell their provider and primary care physician about medication changes, including medication give to them by others.
- \*Keep their appointments. Cancellations without 24 hour notice, that was not a result of a serious emergency, may result in being charged for the appointment.
- \*Let providers know when the treatment plan is not working.
- \*Paying fees or deductibles at the time of treatment. Let providers know about problems with paying fees.
- \*Report abuse or fraud and openly report concerns about the quality of the care they receive.

*My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.*

\_\_\_\_\_  
Client’s Signature (Parent/Guardian Signature if Child Under 14)

\_\_\_\_\_  
Date

*The signature below shows that I have explained this statement to the patient and have offered the member a copy of this form.*

\_\_\_\_\_  
Therapist’s Signature

\_\_\_\_\_  
Credentials

\_\_\_\_\_  
Date

Client Name:

Client ID: