Patient Bill of Rights

This document is provided in accordance with applicable federal and Florida law, including the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations at 45 CFR Part 160 and Part 164, Chapter 456, Florida Statutes, and Chapter 490, Florida Statutes.

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

Right to Respectful Care

You have the right to considerate, respectful, and culturally sensitive care that respects your dignity and privacy.

Right to Confidentiality

Your personal health information and records are confidential and will be protected according to state and federal laws, including HIPAA. You have the right to be informed about how your information is used and disclosed.

Right to Informed Consent

You have the right to receive clear explanations about your diagnosis, evaluation and/or treatment options, risks, and benefits before consenting to any evaluation and/or treatment. Clinical services are not forensic in nature unless separately contracted in writing. Court testimony or legal consultation constitutes a separate professional service.

Right to Participate in Evaluation and/or Treatment

You have the right to be involved in decisions regarding your care and to refuse or discontinue evaluation and/or treatment, except as otherwise provided by law.

Right to Access Your Records

You have the right to review your clinical records and request corrections as allowed by law. Parental access to records is governed by Florida law and any applicable court orders. Valid court orders control access to information.

Right to Privacy

Your sessions and communications will be private, except when disclosure is required or permitted by law (e.g., safety concerns, abuse reporting, court order).

Right to Non-Discrimination

You have the right to receive care free from discrimination based on race, color, national origin, sex, gender identity or expression, sexual orientation, religion, language, age, disability, genetic information, marital status, veteran status, or any other protected status. Reasonable accommodations will be provided consistent with applicable federal and Florida law.

Right to Safe Environment

You have the right to receive services in a safe, accessible, and welcoming environment.

Right to Timely Access

You have the right to reasonable and timely access to care and to be informed of any changes or delays in scheduling.

Right to Communication Access

You have the right to discuss language and communication needs with the practice. Reasonable efforts will be made to support effective communication, and options may include interpreter services or referral to a bilingual provider when clinically appropriate. Availability and costs, if any, will be discussed in advance.

Right to Designate a Legal Representative

You have the right to designate a legal representative or decision-maker for your care when applicable.

Right to Emergency Care Instructions

You have the right to receive guidance on how to access emergency or crisis care outside of regular office hours. This practice does not provide emergency services.

Practice Commitment

The practice is committed to respecting patient rights and providing care consistent with applicable ethical and legal standards.

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 Patient Bill of Rights 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: