Patient Rights and Responsibilities Form

Tranquility Telepsychiatry is committed to providing high-quality mental health services to our patients. In order to ensure a positive and respectful treatment experience for all individuals, we have outlined the following rights and responsibilities for our patients:

Patient Rights:

1. You have the right to receive considerate, respectful, and confidential care at all times.
2. You have the right to be informed about your treatment plan, including the purpose, risks, and benefits of any medications or therapies recommended.
3. You have the right to ask questions, seek clarifications, and participate in decisions regarding your mental health care.
4. You have the right to access your medical records and request amendments or corrections as needed.
5. You have the right to receive care without discrimination based on race, religion, gender, sexual orientation, or any other characteristic.
6. You have the right to voice concerns, complaints, or grievances about your care and have them addressed promptly by our team.
7. You have the right to receive information about our services, fees, and insurance coverage before receiving treatment.
8. You have the right to request a second opinion or seek care from another provider if desired.

Patient Responsibilities:

1. You are responsible for providing accurate and complete information about your medical history, symptoms, and current medications.
2. You are responsible for following the treatment plan agreed upon with your provider, including taking medications as prescribed and attending scheduled appointments.
3. You are responsible for respecting the rights and privacy of other patients, as well as our staff members.
4. You are responsible for communicating any changes in your condition, concerns, or questions to your provider in a timely manner.

5. You are responsible for understanding and following our clinic policies, including those related to appointment scheduling, cancellations, and payments.
6. You are responsible for informing us of any changes in your contact information or insurance coverage.
7. You are responsible for participating actively in your care and engaging in self-care practices recommended by your provider.

By signing below, you acknowledge that you have read and understand the rights and responsibilities outlined above. If you have any questions or require further clarification, please do not hesitate to contact our office.

Patient Name: ____________________________

Date: ______________

Signature: ______________

Thank you for choosing Tranquility Telepsychiatry for your mental health needs. We look forward to supporting you on your journey to wellness.