SHARON SIGESMUND PIERCE & STEPHEN PIERCE
Center for Autism & Developmental Disabilities
At Touro University Nevada

PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Considerate and respectful care and to be comfortable in the environment where care is delivered.
- Request the services of an interpreter, if needed, at no cost to you.
- Receive information about your child's treatment status, course of treatment, and outcomes of treatment in terms you can understand.
- Participate actively in decisions regarding your child's care and to receive as much information about any proposed treatment as you may need in order to give informed consent or to refuse a course of treatment.
- Be advised if the provider proposes to engage in or perform research affecting your child's care or treatment. You have the right to refuse to participate in such research projects and your decisions will **not** affect your right to receive care.
- An estimate for the cost of your child's treatment.
- Reasonable responses to any reasonable requests made for service.
- Have personal privacy respected. Case discussion, consultation, and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. Written authorization shall be obtained before medical records are made available to anyone not directly concerned with your care, except as otherwise required by law. You have the right to access information contained in your records within a reasonable time frame, except in certain circumstances specified by law.
- Receive a written "**Notice of Privacy Practices**" that explains how your Protected Health Information (PHI) will be used and disclosed. Please fill out the Authorization to Release Patient Health Information if you want to share your child's PHI with other health care professionals in establishing a continuity of care.
- Receive care in a safe setting, free from verbal or physical abuse or harassment.
- Receive reasonable continuity of care and know in advance the time of your appointments as well as the identity of the person providing the care.
- Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, or marital status or the source of payment for care.
- Understand and use these rights. If for any reason you do not understand or you need help, Touro University Nevada Center for Autism and Developmental Disabilities will provide appropriate assistance.

You have the responsibility to:
(***Please initial after each highlighted area to confirm that you have read and understand your specific responsibilities with TUNCADD.***)

- Follow Touro University Nevada Center for Autism and Developmental Disabilities (TUNCADD) rules and regulations affecting patient care and conduct. This includes, but not limited to, the following:
  - Show respect for the rights and privacy of other patients and their families while in the waiting room and other public areas of the center. ALL patients are entitled to a private, quiet, therapeutic atmosphere. This includes monitoring the behavior of other children that you may bring with you to appointments as well as the behavior of your child who is a patient of TUNCADD while in the waiting room. Please bring a quiet activity for your child(ren) (e.g., a coloring book, etc.) to use while in the waiting room.
  - Accompany your child(ren) should they need to use the restroom.
  - Complete any intake paperwork provided to you prior to your first scheduled appointment or the appointment may be rescheduled.
  - Unless actively participating in a session or meeting with your child's clinician, please remain in the waiting room area. Should you require entrance to the clinical areas of the TUNCADD, please explain to front office staff your need to be there, and allow them to unlock the door for you. If the front desk is unattended, please ring the bell outside of the front door of the TUNCADD for assistance.
  - **Please limit conversations on cellular phones or with other individuals to the front lobby or a safe area near the entrance of TUNCADD. Once parents are in the viewing/observation area, please turn cellular phones off or on vibrate. Should you choose to use your cellular phone during your**

child's session, for additional safety and well-being precautions, you will be asked to remain in the waiting room for the remainder of your child's session. _____

- Comply with the posted rules and regulations regarding usage of the observation room.
- Comply with all iPad usage rules and privacy expectations when using the iPads for additional video and/or audio of your child in session.
- **Arrive on time for all appointments. If you are up to 15 minutes late, you will be seen but the appointment will end at the scheduled time. If you are more than 15 minutes late, the appointment will be considered a Cancellation or No Show, depending on the circumstances. Rescheduling of make-up sessions that are deemed appropriate and necessary by the Provider. Also, will be contingent on the Provider's approval and availability. _____**
- **Be respectful of your clinician's time. Please provide at least 48 hours' notice for cancellations. Failure to do so may result in the assessment of fees. _____**
- **Continuity of care is critical to your child's success. If you cancel more than 5 appointments in a 2 month period, TUNCADD staff will meet with you to discuss your child's attendance and make appropriate adjustments to your child's schedule, which may include a reduction in the number of weekly scheduled appointments. _____**
- **If you fail to call to cancel an appointment in the TUNCADD (e.g., are a "no show") more than 3 times during a calendar year, a written notice will be sent. Continued violation of this responsibility may lead to a discharge from all CADD services. _____**
- Payment is expected at the time that services are rendered unless prior arrangements have been made.

- Be considerate of TUNCADD facilities and equipment and to use them in such a manner so as to not abuse them.
- Respect the rights and property of other patients and TUNCADD personnel. Just as you want privacy, a quiet atmosphere, and courteous treatment, so do other patients.
- Report, to the best of your knowledge, accurate and complete information regarding any matters pertaining to your child's condition to the clinicians who provide care to your child.
- To provide accurate payment information and insurance benefits.
- **Follow the treatment plan recommended by the clinicians responsible for your child's care. It is your responsibility to tell your clinician whether or not you can and want to follow the treatment plan recommended for your child. The most effective plan is the one which all participants agree is the best and which is carried out exactly. _____**
- Pay bills promptly to assure that your financial obligation to your child's care are fulfilled. Payment is expected at the time when services are rendered unless other arrangements have been established in advance.
- If you should have any questions regarding these Patient Responsibilities, please contact:
  - Joruel Seatriz, CADD Manager at (702) 777-3958 or Lisa Kunz, Director of Clinic Operations at (702) 777-9968.

Consent:

- Audio and video recording are an integral part of the treatment philosophy of Touro University Nevada Center for Autism and Developmental Disabilities. As such, your child's sessions may be subject to audio and video recording. Your signature, below, indicates that you understand this and consent to having your child's sessions, your child, and his/her likeness, will be audio and/or video recorded.
- Touro University Nevada Center for Autism and Developmental Disabilities is a teaching facility for advanced students in multiple disciplines, including clinical psychology and neuropsychology, occupational therapy, speech pathology, behavioral therapy, education, nursing, physical therapy, nursing, and medicine. As such, at any given time, your child's treatment session may be observed by, participated in, or conducted by an advanced student, or multiple advanced students, in one of these disciplines. Students receive substantial supervision by the Clinical Director and other clinical staff of the Touro University Center for Autism and Developmental Disabilities and Touro University Nevada. Your signature, below, indicates that you understand this and agree to consent to the participation of supervised advanced students in my child(ren)'s care.

By signing below, I affirm that I have read, understand, and agree to comply with the above Patient Rights and Responsibilities. I have been provided a copy of this document for my records.

_____ _____ _____

Printed Name & *Signature* of Patient's Representative, Legal Guardian or Representative Date

_____ _____

Signature of Touro Center for Autism and Developmental Disabilities Staff Witness Date