CENTER FOR ADHD, INC. AND
R. TIMOTHY BROWN, M.D., LLC

I value you as a patient of my practice and am committed to providing safe and effective mental health services to you. I want to make sure that you are aware of your rights and responsibilities as a patient. I believe that by doing so, you will be able to best work with me and the office staff in your treatment.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- **Considerate and courteous care** by the office staff and physician.
- **Privacy and confidentiality** about your care, treatment and records.
- **Respect for your time -** be greeted upon arrival & kept informed regarding the approximate waiting time.
- **A safe and comfortable environment** for your care.
- **Complete and current information** regarding your diagnosis, treatment and prognosis; the nature and purpose of tests, prescribed therapy and/or medications, and potential adverse effects associated with the treatment plan.
- **Clear instructions** concerning the need for follow-up visits, referral to other mental health professionals, or additional measures necessary to achieve the desired outcome for your diagnosis.
- **Accept or refuse** any or all of the treatment plan after receiving a complete explanation.
- **Additional professional opinion(s)** on any diagnosis or recommended treatment plan.
- **A copy of medical records** pertaining to your treatment after payment of reasonable copying fees and account balances, if any.
- **Information about your account,** the amount and purpose of charges and our policies regarding payment of charges as well as procedures for resolving conflicts in the settlement of the account.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY TO:

- **Provide correct, complete information** about your health.
- **Follow the treatment plan** ordered by your physician, unless you notify him of concerns.
- **Consider the rights of other** patients and office personnel.
- **Follow office rules and regulations** that apply to patient conduct.
- **Take responsibility for your actions** if you refuse treatment or do not follow your physician's instructions.
- **Meet the financial obligations** for your care as soon as possible.
- **Call the office if unable to keep scheduled appointments** and arrive on time for scheduled appointment.

We want to make sure that you are satisfied with the care you receive from your physician and office staff. If you have questions or concerns, you may speak with the office staff or physician.

I acknowledge that I have read and understand this Notice of Privacy Practices.

Patient's Name:_________________________________ **DOB:**___________________________

Signature of Patient:_____________________________ **Date:**____________________________

If patient is a minor, Parent/Guardian: ____

Form:hippa
2/3/2006

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT'S NAME:______________________ DOB: ____________________

______________________________ ______________________________
SIGNATURE OF PATIENT DATE

IF PATIENT IS A MINOR

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SIGNATURE OF PARENT/GUARDIAN