



**Nicole Ann Cavenagh, PhD**  
**Licensed Psychologist/Pediatric Neuropsychologist**

### **PATIENT RIGHTS AND RESPONSIBILITIES**

You have the **right** to:

- Considerate and respectful care and to be comfortable in the environment where care is delivered
- Receive information about outcomes of your child's evaluation in terms you can understand
- Participate actively in decisions regarding your child's care and to receive as much information as you may need in order to give informed consent
- Be advised if the provider proposes to engage in or perform research affecting your child's care. 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 evaluation
- Reasonable responses to any reasonable requests made for service
- Have personal privacy respected. Case discussion, consultation, and evaluation 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
- 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 and be provided a copy of this document at your request. If for any reason you do not understand or you need help, The Center for Child and Family Development will provide appropriate assistance
- Complaint/Grievance Process – You have the right to express any concerns that may arise and doing so will not negatively impact your child's care. My goal is to resolve these concerns while your child is receiving services at Nicole Ann Cavenagh, PhD by talking directly to the clinical staff responsible for the care of your child. You may also file a complaint or grievance about quality of care concerns with an external agency at any time, including the Utah Division of Occupational and Professional Licensing.

You have the **responsibility** to:

- Follow Nicole Ann Cavenagh, PhD, rules and regulations affecting patient care and conduct. This includes 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 office. ALL patients are entitled to a private, quiet 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 Nicole Ann Cavenagh, PhD, 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
  - Accompanying 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 office, please explain your need to front office staff and allow them to assist you.
  - **Please initial next to each of the following:**
    - **Use of cellular phones (including text messaging) is prohibited in the office. Please turn cellular phones off prior to entering the office \_\_\_\_\_**
    - **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 rescheduled \_\_\_\_\_**
    - **Be respectful of your clinician's time. Please provide at least 72 hours' notice for cancellations. Failure to give at least 72 hours' notice for cancellation for any reason (including traffic, childcare issues, illness, or any other reason) will result in forfeiture of your deposit. Please note that your insurance company cannot be charged for a failed or cancelled appointment and you will be responsible for payment \_\_\_\_\_**
    - **If you do not attend a session and do not call to cancel, all of your future appointments will be cancelled \_\_\_\_\_**
    - **Once an evaluation has begun, it must be completed in a timely manner. It is your responsibility to work with our staff to reschedule any cancelled or failed appointments as soon as possible \_\_\_\_\_**
- Be considerate of 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 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
- 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 Fees may be paid by cash, check, or credit card (please see front office staff for credit cards accepted).

**Consent:**

- Audio and video recording are often a necessary component of a child's evaluation. 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 audio and/or video recorded. These recordings will be stored and destroyed in accordance with legal and ethical guidelines.

By signing below I attest that I have read, understood, and agree to comply with the above Patient Rights and Responsibilities.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Patient's Representative (if patient is a minor)

\_\_\_\_\_  
Signature of Patient (or Patient's Representative if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Witness

\_\_\_\_\_  
Date