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## All Day Medical Care Clinic Patient Rights and Responsibilities Form

### Patients have the right:

1. To be treated humanely, with dignity, and respect.
2. To not be discriminated against due to race, religion, ethnicity, gender, sexual orientation, or disability.
3. To receive treatment appropriate to their mental health condition.
4. To have diagnosis and treatment explained in understandable terms.
5. To participate in the formulation and revision of the treatment plan.
6. To refuse treatment, request another provider, or seek a referral outside of the practice.
7. To receive services that adhere to the principles of confidentiality and privacy except for the following specialized circumstances:
  - a. When circumstances place the patient's welfare or that of others in immediate danger.
  - b. When disclosures made by the patient raise the suspicion of the child's physical, mental, or sexual abuse or neglect, or if an adult discloses an allegation of abuse in their childhood. In this situation, the law requires a report be made to the appropriate agency, usually Social Services.
  - c. When a court order requires testimony or release of patient's records.
  - d. In a circumstance where the provider determines that consultation within the practice is needed in order to provide optimal treatment, in which case the utmost discretion will be used to insure privacy.
8. To access your medical record as deemed appropriate by the provider.

### Patients have the responsibility:

1. To know the benefits and exclusions of your insurance coverage and to provide us with current insurance information.
2. To make regular and prompt payments for services rendered.
3. To keep scheduled appointments. Patients will be charged for missed appointments or cancellations for which 24-hour notice has not been given.
4. To follow the mutually agreed upon treatment plan.
5. To be open and honest in sessions.
6. To report any safety concerns or abuse allegations to your provider.
7. To discuss with your provider any concerns about treatment, including the desire to terminate treatment.

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

Date: \_\_\_\_\_

Signature: \_\_\_\_\_