



Sage Neuroscience Center

7850 Jefferson ST NE Suite 300, Albuquerque, NM 87109

Statement of Your Rights as a Patient

You have the right to:

1. Be treated with dignity and respect at all times. You and your family members are recognized as individuals with personal needs, feelings, preferences, and requirements.
2. Be fully informed of all the services related to your care.
3. Be fully informed of your rights related to your care in any Sage Neuroscience program.
4. Be heard and included in the treatment planning process and in any decisions affecting your future.
5. Experience freedom of thought, conscience and religion. Whenever practical, your wishes will be followed with regard to religious participation or abstinence from worship.
6. Receive services that provide access to cultural practices and traditional treatments in accordance with your wishes and assessed needs.
7. Receive appropriate medical care.
8. Receive information necessary and as appropriate in order to give informed consent prior to the start of any treatment.
9. Voice opinions and offer suggestions in relation to policies and services offered by Sage Neuroscience without fear of interference, coercion, discrimination, or reprisal.
10. File a grievance regarding the care or treatment being rendered to you by staff at Sage Neuroscience. Grievance procedures will be made available to you upon request.
11. Confidential treatment of your record. Protected health information will not be released without prior consent except for treatment, payment, public health risks, emergency situations as described in the notice of privacy practices, or as otherwise required by law.
12. Refuse treatment to the extent permitted by law and to be informed of the consequences of this right.
13. Inspect and receive a copy of information that is in the client record within certain limitations defined by state and federal statutes.
14. Request a restriction on the use or disclosure of your protected health information and to request to withdraw that restriction. The agency does not have to agree to the additional restrictions requested.
15. To submit clarifying or correcting statements to your protected health information.
16. Know to whom your protected health information has been disclosed for reasons other than treatment, payment, or healthcare operations.

Patient Name: Please Print

Patient Signature

Date