



It is our philosophy at Nova Recovery LLC that in order to provide you with the best possible care we must make it our priority to protect your individuality, dignity, and fundamental human, civil, constitutional, and statutory rights. Please be advised that your rights include the following:

(a) Nova Recovery, LLC shall respect, protect, implement and enforce each client right required to be contained in the facility's Client Bill of Rights. The Client Bill of Rights for all facilities shall include:

- (1) You have the right to accept or refuse treatment after receiving this explanation.
- (2) If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
- (3) You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for dressing in rooms with more than one client, and privacy for your personal needs. There will be no more than eight persons in a room.
- (4) You have the right to be free from abuse, neglect, and exploitation.
- (5) You have the right to an environment that preserves dignity, respect, and contributes to a positive self-image.
- (6) You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
- (7) You have the right to be told about the program's rules and regulations before you are admitted, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusion.
- (8) You have the right to be told before admission:
 - (A) the condition to be treated;
 - (B) the proposed treatment;
 - (C) the risks, benefits, and side effects of all proposed treatment and medication;
 - (D) the probable health and mental health consequences of refusing treatment;
 - (E) other treatments that are available and which ones, if any, might be appropriate for you;
 - (F) the expected length of stay; and
 - (G) what is to be expected of treatment.
- (9) You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
- (10) You have the right to meet with staff to review and update the plan on a regular basis.
- (11) You have the right to refuse to take part in research without affecting your regular care.
- (12) You have the right not to receive unnecessary or excessive medication.
- (13) You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
- (14) You have the right to be told in advance of all estimated charges and any limitations on the length of services of which the facility is aware.
- (15) You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
- (16) You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
- (17) You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
- (18) You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Commission on Alcohol and Drug Abuse.
- (19) You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.
- (20) You have the right to accommodate the right to pastoral and other spiritual services, within a 24-hour setting.
- (21) You the right to have your cultural and personal values, beliefs and preferences be respected.

- (22) You have the right to amend personal health information and obtain information on disclosures of information, in accordance to law.
- (23) You have the right to have Nova define your rights when handling emergencies.
- (24) You have the right to receive information in a manner you understand.
- (25) Nova Recovery, LLC respects your right to collaborate in decision about CTS.
- (26) You have the right to give or withhold informed consent to produce or use recordings, films or other images of client for purposes other than his/her care.
- (27) Nova Recovery, LLC protects clients and respects rights during research, investigation and clinical trials.
- (28) Nova Recovery, LLC respects the right of the person to receive information about the staff responsible for his/her care.
- (29) You have the right to be free from neglect, exploitation and verbal, mental, physical and sexual abuse.
- (30) You have the right to keep possession by bedside unless it interferes with care, treatment, or services.
- (31) You have a right to exercise citizenship privileges such as voting privileges. You will be provided absentee ballots, transportation to polls, etc. upon request.
- (32) You have the right to access protective and advocacy services.

(b) For residential sites, the Client Bill of Rights shall also include:

- (1) You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others.
- (2) You have the right to communicate with people outside the facility. This includes the right to have visitors, to make telephone calls, and to send and receive sealed mail. This right may be restricted on an individual basis by your physician or the person in charge of the program if it is necessary for your treatment or for security, the reason, length of time, and removal of restriction will be explained and documented in the client chart, but even then you may contact an attorney or the Texas Commission on Alcohol and Drug Abuse at any reasonable time. Restrictions on communication will be reduced or eliminated when no longer therapeutic.
- (3) If you consented to treatment, you have the right to leave the facility within four hours of requesting release unless a physician determines that you pose a threat of harm to yourself and others.
- (4) Each facility promotes an awareness of day, time and season by clocks, calendars, outdoor recreational activities, outdoor sitting areas, and holiday events.

(c) If a client's right to free communication is restricted under the provisions of paragraph (b)(2) of this section, the physician or program director shall document the clinical reasons for the restriction and the duration of the restriction in the client record. The physician or program director shall also inform the client, and, if appropriate, the client's consenter of the clinical reasons for the restriction and the duration of the restriction.

The effects of compliance with this policy ensures that client's rights and grievance procedures are understood by the clients and their applicable consenters and supporters. Clients that enter any LOC with Nova Recovery, LLC are voluntary clients, and have the right to receive and understand all required information. Nova Recovery, LLC staff shall always assist a client who has questions about their rights, filing a complaint or grievance, and/or their care.

Substance Abuse Facility Investigations (MC 1979)
 Texas Department of State Health Services
 PO Box 149347
 TX 78714-9347
 Toll Free: (800) 832-9623 Phone: (512) 834-6700

Client Signature

Date

Staff Signature

Date

Client Receives Copy



By signing below, I hereby authorize Nova Recovery, LLC to release and/or to obtain information with respect to any medical, psychiatric, drug and/or alcohol related conditions obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers listed below. The type of information authorized for disclosure includes, but may not be limited to, that which is indicated below. **I understand that my signature below will not have effect on the ability or inability to determine, limit or restrict my treatment.**

Client Name: _____

RELEASE TO / RELEASE OBTAINED FROM		PURPOSE OF DISCLOSURE	TYPE OF INFORMATION TO BE DISCLOSED	INITIAL EACH CONSENT TO RELEASE
REFERRAL	Primary	To identify persons supporting and using services. To aid in diagnosis, continuing care, and treatment.	1) Notification of admission and discharge, including assessment, UDS results, attendance, discharge planning and summary. 2) Progress and treatment reports.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone			
	Address			
PRIMARY CARE PHYSICIAN	Primary	To aid in diagnosis, continuing care and treatment.	1) Notification of admission and discharge, including assessment, USD results, discharge planning and summary. 2) Progress and treatment report, including attendance. 3) History and physical and Psychosocial Assessment.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone			
	Address			
FAMILY MEMBERS OR SIGNIFICANT OTHERS	Primary	To facilitate understanding and support in treatment. To aid in continuing care and treatment.	1) Notification of admission, information on client's treatment plan, discharge and continuing care plans, and financial issues.	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone			
	Address			
INSURANCE	Primary	To aid in diagnosis, continuing care, payment and treatment.	1) Notification of admission request, admission, discharge, including assessment, UDS results, discharge planning and summary. 2) Progress and treatment reports, including group, individual, family sessions, attendance, and other assessments and services. 3) History & physical, consultation reports.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone			
	Address			

LEGAL	Primary	Purpose: _____	Information to be disclosed or obtained: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone	_____	_____	
	Address	_____	_____	
		_____	_____	
		_____	_____	
OTHER	Primary	Purpose: _____	Information to be disclosed or obtained: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone	_____	_____	
	Address	_____	_____	
		_____	_____	
		_____	_____	
OTHER	Primary	Purpose: _____	Information to be disclosed or obtained: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone	_____	_____	
	Address	_____	_____	
		_____	_____	
		_____	_____	

OTHER	Primary	Purpose: _____	Information to be disclosed or obtained: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone	_____	_____	
	Address	_____	_____	
		_____	_____	
		_____	_____	
OTHER	Primary	Purpose: _____	Information to be disclosed or obtained: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Phone	_____	_____	
	Address	_____	_____	
		_____	_____	
		_____	_____	

Client Name: _____

The above releases, initialed by me, may be revoked or revised by me in writing at any time. If not previously revoked, the release will expire 1 year of date of signature below.

This release is valid until _____, 20__ or until revoked by me in writing

1 year from the date of signature

and submitted to Nova Recovery, LLC. I understand I have a right to receive a copy of this authorization.

Client Signature

Date

Nova Recovery, LLC Staff

Date

Confidentiality Prohibition on Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part II and 45 CFR HIPAA) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.