



## ELK MEADOW ENDURING CONNECTIONS ~ EMEC

685 Citadel Drive East, Suite 510, Colorado Springs, Colorado 80909  
[www.enduringconnections.org](http://www.enduringconnections.org) ~ [connect@enduringconnections.org](mailto:connect@enduringconnections.org)  
Phone: 719. 452. 0393

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### CLIENT RIGHTS

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1. I understand that I have the right to decide not to enter therapy nor engage in other services provided through EMEC (although depending on my situation there may be legal consequences), and to terminate therapy at any time.
  2. I understand that I have the right to a safe environment during the provision of services - free from physical, sexual, and emotional abuse, gaslighting, or any other unsafe practice. Any abuse should be immediately reported to the grievance board at DORA.
  3. I understand that I will not be discriminated against due to race, ethnicity, sexual identity, gender identity, religious beliefs, socioeconomic status, justice involvement, etc. I understand that I will not be discriminated against nor denied treatment for physical, psychological, or emotional presenting concerns. If the facility is not equipped to address my specific presenting concerns, due to limited resources/staff limitations, I will be referred to an agency that is better equipped to address my needs.
  4. I have a right to know about my diagnoses, treatment plan, proposed interventions, potential risks & benefits, progress, fees, length of sessions, and duration of treatment.
  5. I understand that my right to confidentiality will be protected and information regarding my treatment will not be disclosed to any person or agency without my written permission (ROI), except under circumstances where the law requires such information to be disclosed. I have the right to know the limits of confidentiality, the situations in which a therapist and/or agency is required to disclose such information to outside agencies, and the types of information that must be disclosed.
  6. I understand that I have the right to information about the professional capabilities and limitations of any provider involved in my care, their certifications and licensure, education and training experience, specialization, and clinical supervision.
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Client's Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_