



## WELCOME TO MOUNT SINAI MORNINGSIDE PSYCHIATRY

### WHAT YOU CAN EXPECT FROM US:

- **High –quality care to promote your mental health, wellness and recovery** – Focused on your individual needs and goals.
- **Confidentiality** – You may choose to give consent to share information with others, such as family or other providers.
- **Availability** – On time, reliable care and alternative coverage when we are not available.
- **Respect** – Compassionate, respectful response to your concerns.
- **Hope** – We believe in your capacity to succeed in getting well and achieving your goals.

### What we expect from you:

- **Engagement and Motivation** – Please engage with your treatment providers to create and actively participate in your treatment plan to work towards your goals. We will support you in this process.
- **Timeliness** – Arrive 10-15 minutes early to register for your appointment. If you need to cancel or change your appointment, call at least 24 hours in advance and reschedule.
- **Attendance** – Commit to attend all your appointments. We can work with you to overcome any obstacles to your attendance. If your attendance falls below 75% over two months or over the course of 4 monthly visits (including missed appointments and late cancellations), we will need to discuss other treatment options including discharge from the clinic.
- **Inform** – Let your clinician know about any important issues of safety concerns; let your prescriber know about any side effects or medical problems; let the staff know about any changes in telephone number, address, insurance.
- **Respect and Safety** – Treat others with respect in the clinic. Yelling, cursing, threatening, or other verbally abusive behaviors are not acceptable. Violence or threats of violence to staff or other patients will result in termination of care from this clinic. Weapons may not be brought in the clinic.
- **Address substance Use** – We will work with you on substance issues as well as mental health
- **Ask questions and give feedback** – We will be happy to answer any questions you have about your treatment. If you have concerns, recommendations or complaints about your treatments, please feel free to discuss with your provider, the front desk receptionist, or the clinic director.
- **Plan for the Future** – Upon completion of each stage of your treatment goals, you and your provider will work together to make a plan for your future treatment, if needed. If you decided to end treatment before this, please let us know so we can assist you with a follow-up plan.

**I have read these expectations and agree to follow them.**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

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

Clinician Name: \_\_\_\_\_