Tracy Crudup
VAN PELT COUNSELING CENTER

TREATMENT CONSENT – REGISTRATION PACKET

Please review thoroughly and **completing all pages including initialing EACH** page at the bottom.

NAME_____

ADDRESS_____

_____

PHONE_____

ACCOMPANIED BY_____RELATIONSHIP TO CLIENT_____

You may choose to have someone accompany you to the session with the understanding that you are the identified patient, the privileged and confidential nature of the appointment would be exposed to the accompanying support person and you are agreeing to such exposure. Otherwise, all session are confidential.

CLIENT'S DATE OF BIRTH_____ GENDER_____MARITAL STATUS_____

EMPLOYMENT OR SCHOOL STATUS_____EMPLOYER_____

IS THIS ISSUE RELATED TO EMPLOYMENT?_____CAR ACCIDENT?_____STATE WHERE ACCIDENT OCCURRED_____

ANY PENDING LAWSUITS?_____DIVORCE LAWSUITS?_____

CONTACT

EMAIL ADDRESS _____

Appointment reminder will be sent by text automatically to the phone number listed on your account.

EMERGENCY & RESPONSIBLE PARTY

EMERGENCY CONTACT **NAME/RELATION** _____NUMBER_____

Name and Address of PERSON for LEGAL & FINANCIAL RESPONSIBILITY for a MINOR CHILD:

_____

CONFIDENTIAL CLIENT QUESTIONNAIRE – INDIVIDUAL

Briefly describe your reason for seeking help and your goals for treatment: _____

_____

CIRCLE ALL PRESENTING ISSUES THAT APPLY TO YOUR REASON(S) FOR SEEKING TREATMENT:

Anxiety	Depression	Mood Swings
Concentration	Memory	Hopelessness
Panic Attacks	Fear	Trauma
Alcohol Use	Drug Use	Legal Issues
Life Transitions	Self-Control	Aggression/Anger
Marital/Relationship Issues	Family Issues	Parenting Issues
Work/Career Issues	School/Education Issues	Spiritual Issues
Stress	Fatigue	Sleep Problems
Headaches	Appetite	Chronic Health Concerns
Other physical complaints	Inferiority Feelings	Motivation
Financial Difficulties	Self-harm/Cutting	Infertility

****ARE YOU CURRENTLY** HAVING ANY THOUGHTS OR HURTING YOURSELF_____ OR ANYONE ELSE?_____

Any addictions issues? Drug/ alcohol? Past or Current._____

How were you referred to this particular clinician? _____Insurance Company/EAP _____Friend _____Psychology Today _____Internet Search/Google _____Health Professional (Name)_____

1. If you are currently under the care of a psychiatrist, please state condition for which you are being treated, and list the psychiatrist's name and phone number:

_____

2. Have you ever been admitted to a psychiatric hospital? _____If yes: list reason for and date of admission.

_____

3. Have you seen a mental health professional in the past? No Yes;
Please list name of professional_____

4. **Please list any medications you take regularly for mental health issues.** (Include name of medication, dose and frequency)

_____

5. Current or expected legal involvement? Yes No If yes, please explain:
_____

6. History of arrests? Yes -No
Charge/Result_____

FINANCIAL AGREEMENT

Payment is due at the time services are rendered. This office is accepts private pay and some insurance plans. Cash, check, Visa, MasterCard, HSA accepted. *The fee for service is due and payable at the beginning of each session; this includes co-pays, co-insurance or full amount if you have not met your deductible.*
Please make checks payable to **Tracy Crudup, M.S.**

Insurance Fees: Will bill your insurance, you will pay your co-pay, co-insurance and/deductible at appointment.

****According to the No Surprises Act of Jan 1, 2022**, a good faith estimate is required for private pay patients. This is an estimate of what services will cost. The total cost of services is unknown, it is based upon the number of appointments and services provided. The frequency of your appointments will determine the ultimate cost. As noted below, INTAKE APPOINTMENTS (CPT 90791) are _$_____, and follow-up appointments, whether individual or family are_$_____.

Initial Each Section:

_____**Missed appointments policy** – If you are unable to keep an appointment, you must notify me at **901-466-8773**. Appointments must be cancelled at **least 24 hours prior** to your appointed session time; otherwise, your account will be charged **$50** late cancellation fee. If you **fail to show** for your appointment without notice, your account will be charged the **full session fee**. It will be due and payable by your credit card on file and I acknowledge and approve this transaction. ***In the event of extremely bad weather such as ice and snow, please call the office to confirm office hours.***

_____**Payment**--There will be returned check fee of $35 should your check be returned by your bank for insufficient funds.

_____**Legal/Professional Fees**--There may be charges for questionnaires or letters that are not normally required for billing or treatment purposes, including but not limited to lengthy phone consults, or medical record requests. *You are agreeing to not depose me by signing this Consent Form*; but should I be ordered to testify, there will be a fee of no less than $1250. The $1250 reserves a maximum of 4-hour block. The minimum block to reserve after the initial 4 hours is another 4 hours at $950. **This is non-refundable** when reserved and payable at the time of reserve for me to clear my schedule for your case for any legal deposition or court testimony, proceedings, or meetings. Expenses I may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at $225 per hour and are in addition to the minimum $1250. My fee for matters involving the courts, included but not limited to reviewing case files, consultations with attorneys and/or patients, or preparation for court matters by court order, will be assessed at $225 per hour with a minimum of 2 hours, which is non-refundable.

_____**Insurance**—If you choose to utilize your insurance that I am paneled with, I will file your claim. Filing is a courtesy. You are ultimately responsible for the charges. You may choose not to utilize your insurance and private pay by waiving right to file. If I am out-of-network with your insurance company you can be provided with a *superbill* to submit to your insurance for possible reimbursement. This reimbursement is between you and your insurance company.

_____**Delinquent accounts**--In the event that the account becomes delinquent, the responsible party agrees to pay for attorney or collection fees. The account will become delinquent after it has matured to 60 days from the date of service. Once in collections, there will be an added 25% to the account balance plus incurred legal fees. The office of Tracy Crudup will determine the collection agency.

Intake Appts $_____Follow up Appts $_____
By signing below you have agreed to all the terms in this financial agreement.

SIGN and DATE_____

Patient Initial _____Tracy Crudup, M.S., Clinical Mental Health Therapist

FINANCIAL RESPONSIBILITY

A credit card is required on file for each visit.

This will greatly improve office efficiency for any unpaid balance, including but not limited to missed appointments without notice fees. You may still pay by cash, check, health savings account or a different credit card at the time of your appointment. A copy will be made at the office.

American Express Visa MasterCard Discover

Account Number_____-_____-_____-_____ Exp Date_____

Security Digit code on back of card (front for Am Ex)_____

Billing Zip Code_____

Name as it appears in card_____

Email for receipt_____

INITIAL:

_____I understand that in the event that I pay by check and the check is returned for insufficient funds, I expressly authorize this credit card on file to be charged the balance plus applicable fees, including $35 for insufficient funds.

By providing this information I am authorizing Tracy Crudup-Van Pelt Counseling Center, to charge outstanding balances to this credit card and I further accept and acknowledge this policy, its terms and conditions. There is a $3 charge for all credit transactions.

Signature_____Date_____

ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically through funds transfer by a payment card using ***Square*****.** We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible. *Please Be Aware of the Following:*

_____After using ***Square*** to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session. It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to. This is a result of your previous usage of your card the email and phone number associated with card.

So before using a card to pay for services, please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before? Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

_____In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to:
Tracy Crudup-- Van Pelt Counseling Center. Please consider who might have access to your statements before making payments by credit card.

_____If you are using a *Health Savings Account (HSA) or Flexible Spending Account (FSA)* payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is a possibility it could later be denied. In this event, you are responsible for full payment balance.

By signing this form you are acknowledging and agreeing to the above stated information.

Name_____Date_____

HIPAA/INSURANCE RELEASE FORM

Tracy Crudup, MS, LPC-MHSP will bill your insurance company as a courtesy for reimbursement of services. Please verify with your provider all of your behavioral health/mental health coverage. It is your responsibility to pay any co-pay, co-insurance or deductible you may have at the time of service.

INSURANCE INFORMATION:
Insurance Co. _____ Policy # _____
Group# _____Member ID_____

Policy Holder _____ DOB: _____ SS# _____ _
Relation to Patient: _____

Insurance Co. Address:_____
Insurance Phone: _____Effective Date:_____
Co-Pay Amount $_____Mental Health Deductible $_____Number of Sessions_____

EAP authorization #_____Company_____

INITIAL ALL:

_____ File my insurance.
_____ I do not file Medicare.
_____I agree to be responsible for the payment (including deductible, copayment or co- insurance) for services rendered, regardless of my insurance status.
_____ I am responsible for cancellation/no show fees. These fees will not be submitted to my insurance company.
_____**I certify that all information provided within this registration packet (consent for treatment) is true and correct.**

_____By requesting that Tracy Crudup, MS, LPC-MHSP file the charges to your insurance company, you understand that securing benefits under your plan will require that the therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. For utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for Tracy Crudup, MS, LPC-MHSP, to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information.

_____*I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed*.

Signature_____Date_____

Read carefully regarding insurance.

Patient Initial _____Tracy Crudup, M.S., Clinical Mental Health Therapist

File insurance—sign section A and C

Do NOT File Insurance—check section B and sign section C

Do to requests of your personal information from your insurance company, you may choose not to utilize your insurance.

Section A: Initial _____File my insurance.

Section B: Not Utilizing Your Insurance-- HIPAA Agreement

If you choose not to utilize your health insurance benefits to pay for services, please check the appropriate box below and initial:

□ I **do not** have health insurance and will be paying for professional services directly as private pay.

□ I **do have** health insurance (possible in network or out) but am **choosing not to file** any claims for benefits related to services. I will utilize private pay.

□ I have insurance but Tracy Crudup, M.S., **is not paneled** with my insurance. I will utilize private pay and ask for a superbill if I choose to submit (on my own) for possible out of-network benefits reimbursement.

_____If you have insurance but choose not to utilize it at this time, we ***cannot*** submit claims for ***prior services*** at a later date should you change your mind about using your insurance.

Section C: Initial and Sign:

_____I understand that if I choose to later use my insurance, that Tracy Crudup, MS, LPC-MHSP (dba) Van Pelt Counseling Center is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance. If I choose to opt in, I will notify her and the effective date will be the date of notification and cannot be backdated to previous sessions. *You have a right to not use your medical/behavioral benefits.*

By signing this consent, you are consenting to pages 1-9, keeping pages 10-13 for emergency contact information and patient rights information.

Signature:_____ Date:_____

Provider Signature:_____Date:_____

YOUR FILE WILL AUTOMATICALLY BE IN DISCHARGE STATUS FOR THERAPY NON-COMPLIANCE AFTER 45 DAYS IF YOU HAVE NOT SCHEDULED AN APPOINTMENT. THERAPY CAN RE-START AT ANY TIME.

Patient Initial _____Tracy Crudup, M.S., Clinical Mental Health Therapist

CONFIDENTIALITY

Your information including the fact that you have initiated treatment is confidential within the limits of the law. There are several important exceptions however:

- Any physical or sexual child abuse that is reasonably suspected or reported to me
- Any reasonable suspicion of abuse of an elderly person
- Any threats of suicide, homicide or serious danger of violence
- Clients may sign a release of information for me to communicate with an identified third party (e.g. medical doctor, previous counselor, etc.)
- Information necessary for supervision or consultation (client identity will remain confidential)
- Information required by law or court mandated or Information required for insurance reimbursement (at the client's request)

PRIVACY INFORMATION and CLIENT RIGHTS AND RESPONSIBILITIES

This registration packet contains all relevant HIPAA compliance information (see "Notice of Privacy Practices"). Your rights and responsibilities are also included in this packet for your information, pages 10-13 are yours to keep. Additionally, this information can be found on my website www.vanpeltcounselingcenter.com. By signing this consent form, you acknowledge receipt of and/or access to the applicable privacy information and client rights and responsibilities.

EMERGENCY SITUATIONS

In case of an emergency involving physical threat or danger CALL 911. In case of an emergency mental health issue, you may call 911 or go to your nearest hospital emergency room. If you have an important, non-emergency need, you can leave a message for me at 901-466-8773. Return calls may take up to 24 hours.

- ❑ You may have a copy of this form for future reference.
- ❑ By signing below you do hereby consent to treatment services provided by Tracy Crudup, M.S. You declare that you have the legal right and competency to consent to treatment for yourself and/or any minor child here named.

Consent Update Form

I am consenting to update my informed consent, Pages 1-8 for Tracy Crudup, LPC-MHSP, NCC-BC (dba) Van Pelt Counseling Center by signing and dating this form. All information previously provided will continue for an additional year.

YEAR 2023 New contact info?_____New insurance?_____New credit card on file?_____

_____
Patient signature Date

YEAR 2024 New contact info?_____New insurance?_____New credit card on file?_____

_____
Patient signature Date

YEAR 2025 New contact info?_____New insurance?_____New credit card on file?_____

_____
Patient signature Date

YEAR 2026 New contact info?_____New insurance?_____New credit card on file?_____

_____
Patient signature Date

Your page to keep (pages 10-13).

CLIENT RIGHTS AND RESPONSIBILITIES

RESPONSIBILITIES:

Your willingness to actively participate in treatment plays a crucial part in achieving treatment success. Therefore, you have the following responsibilities:

- The responsibility to provide accurate and complete information as needed for your treatment planning.
- The responsibility to update any changes in information needed for your treatment planning.
- The responsibility to make it known whether or not you understand your treatment plan.
- The responsibility to actively participate in your treatment.
- The responsibility to indicate when you are unwilling and/or unable to comply with your treatment plan.
- The responsibility for your actions if you refuse to comply with treatment plan recommendations.
- The responsibility to follow all rules and regulations established to maintain a safe treatment environment.

RIGHTS:

You have the following rights:

- The right to participate in planning your treatment program.
- The right, to the extent permitted by the law, to refuse specific treatment, procedures, unless there is danger of harm.
- The right to file a grievance, should you feel you are treated unfairly.
- The right to confidentiality.
- The right to be free from discrimination including discrimination because of race, religion, sexual preference, age or disability.
- The right to privacy as appropriate to your treatment setting.
- The responsibility to respect the rights and confidentiality of others.

EMERGENCY SITUATIONS

In case of an emergency involving physical threat or danger **CALL 911**. In case of an emergency mental health issue, you may call 911 or go to your nearest hospital emergency room. If you have an important, non-emergency need, you can leave a message for me at **901-466-8773**. Return calls may take up to 24 hours.

NOTICE OF PRIVACY PRACTICES

Tracy Crudup, M.S.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. You will find Tracy Crudup, M.S. will do all she can to protect the privacy of your mental health records.

As required by "HIPAA", this explanation was prepared to explain how therapists are required to maintain the privacy of your health information and how Tracy Crudup, M.S. may use and disclose your health information. The mental health licensing law provides extremely strong privileged communication protections for conversations between your mental health provider and you. There is a difference between privileged conversations and documentation in your mental health records. Records are kept, documenting your care, as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible without your authorization to insurance companies and other third-party reviewers.

HIPAA provides privacy protections about your personal health information. We may use and disclose your medical and mental health records *without authorization* for each of the following: treatment, payment and health care. These functions require release of "protected health information" (PHI). Below, we have defined these three (3) functions: *treatment, payment, and health care operations*.

- **Treatment Purposes** refers to Tracy Crudup, M.S. coordinating or managing your mental health care treatment. Examples of this would a counseling session in which the healthcare provider records information in the health record. Or during the course of your treatment, the treating provider determines she will need to consult with another specialist in the area. She may share the information with such specialist to obtain his/her input. Also, this includes communication between Tracy Crudup, M.S. and any other treating provider for the purpose of providing health care to you. While this is permitted by HIPAA, Tracy Crudup's standard practice is to require written releases for this information in many situations.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Examples of this would be sending a bill for your visit to your insurance company for payment or the health insurance company or a business associate helping us obtain payment, and them requesting information from us regarding your medical care. She will provide information to them about you and the care given.
- **Health care operations** include the business aspects of running her practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. She will share information about you only if it is necessary to obtain and continue your services.

Routine Uses and Disclosures

The use of your protected health information is necessary to perform routine activities at this office such as filing insurance claims, scheduling appointments, keeping records and other tasks. You will not need a written authorization to allow us to perform these duties for you.

She may contact you via telephone (a message may be left) or mail to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. She will not require your authorization.
She may also create and distribute non-identifiable health information by removing all references to individually identifiable information for marketing or research. She will not require your authorization. Unless required by law, most other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing, except to the extent that we have already taken actions relying on your authorization; we refer to this as "Authorized Non-Routine Disclosures".

Uses and Disclosures of Protected Health Information Requiring Authorization, Authorized Non-Routine Disclosures

Tennessee requires the provider to get authorization and consent for treatment, a release of payment and to conduct healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. She may disclose Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations without your consent.

Additionally, if you ever want Tracy Crudup's office to send any of your protected health information of any sort to anyone outside our office, you will always first sign a specific authorization to release information to this outside party unless stated otherwise in the PHI section of this Notice. The release is available upon request.

There is a third, special authorization provision potentially relevant to the privacy of your records: Psychotherapy Notes. In recognition of the importance of the confidentiality of conversation between mental health providers and patients in treatment setting, HIPAA permits keeping separate "Psychotherapy Notes" separate from the overall "designated medical record". Insurance companies cannot secure "Psychotherapy Notes" without your written authorization. "Psychotherapy Notes" are the notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's "designated medical record." A patient's authorization is required for the use and disclosure of psychotherapy notes except for use by the originator of the notes for treatment, or for use of disclosure by the covered entity for its own mental health training programs, or use or disclosure by the covered entity to defend itself in a legal action or other proceedings brought by the patient or guarantor; and/or when required by law.

"Psychotherapy Notes" are necessarily more private and contain much more personal information about you, hence the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at our office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical test, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

By law, the following protected health information may be released without your consent or authorization:

- Child abuse
- Suspected sexual abuse of a child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing boards for mental health providers in Tennessee)
- Judicial or administrative proceedings (i.e., if you are ordered here by the court for an independent child custody evaluation in a divorce)
- Serious Threat to Health or Safety (i.e., our "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under workers compensation, all of your care is automatically subject to review by your employer and/or insurer(s), except Psychotherapy Notes. If requested, we will obtain your written authorization before releasing any Psychotherapy Notes, unless required by law.
- Disclosures to coroners, medical examiners, and funeral directors
- Disclosures to organ procurement organizations

Your Health Information Rights

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to Tracy Crudup – She is not required to grant the request but she will respond to any request;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice");
3. Right to inspect and copy your records in the designated mental health record set and billing record – you may exercise this right by delivering the request in writing to this office using the form we provide to you upon request; or you have the right to appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and

require that the request for amendment and any denial be attached in all future disclosures of your protected health information;

5. Right to receive an accounting of non-authorized disclosures of your health information as required to be maintained by law by delivering a written request to her office using the form she provide to you upon request. An accounting will not include internal uses of information from treatment, payment, or operations, disclosures made to you or made at your request, or non-medical records (clinical information) disclosures made to family members or friends in the course of providing care;
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to her office using the form she gives you upon request; Example would be you may not want your bills sent to your home address so you may request them to be sent to another location of your choosing;
7. Right to revoke your authorization of your protected health information except to the extent that action has already been taken; and,

If you want to exercise any of the above rights, please contact Tracy Crudup, M.S. (901) 466-8773 in person or in writing. She will provide you with assistance on the steps to take to exercise your rights.

Tracy Crudup Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by the state and federal law;
- Provide you with a notice of her duties and privacy practices;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of non-authorized disclosures

She appointed herself as a "Privacy Officer" for this practice per HIPAA regulations. If you have any concerns of any sort that her office may have somehow compromised your privacy rights, please do not hesitate to contact Ms. Crudup, the "Privacy-Complaint Officer" immediately about this matter. You will find she is always willing to talk to you about preserving the privacy of your protected mental health information.

Ms. Crudup reserves the right to amend, change, or eliminate provisions in her privacy practices and access practices and to enact new provisions regarding the protected health information he maintains. If her information practices change, she will amend her Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting her office and picking up a copy.

Please contact us for more information by asking to speak to our Privacy Officer or for written enquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint, contact:
The U.S. Department of Health and Human Services
Office of Civil Rights