# BEACON MENTAL HEALTH

3100 NE 83RD STREET, SUITE 1001
KANSAS CITY, MO 64119
(816) 468-0400

**CLIENT RIGHTS:**

As a client of Beacon Health you shall be entitled to the following rights and privileges without limitation or restriction:

1. To humane care and treatment;
2. To receive prompt evaluation, care and treatment;
3. To be fully informed about the course of your care and decisions that may affect treatment;
4. To receive these services in the least restrictive environment;
5. To receive these services in a clean and safe setting;
6. To be treated with respect and dignity as a human being;
7. To receive timely and accurate information to assist in making sound decisions about treatment;
8. To be subject of an experiment or research only with consent or the consent of a person legally authorized to act on behalf of the client;
9. To confidentiality of information and records in accordance with federal and state law and regulation, as explained in the Notice of Privacy Practices.
10. To have the same legal rights and responsibilities as any other citizen, unless otherwise stated by law;
11. Not to be denied admission or services because of race, creed, sexual orientation, marital status, gender, gender identity, national origin, disability or age;
12. To be free from abuse, exploitation, retaliation, humiliation, and neglect;
13. To have records and documents explained;
14. To medical care and treatment in accordance with accepted standards of medical practice.
15. To request a second opinion in accordance with Beacon's policies and procedures.
16. To consult with a private, licensed practitioner at one's own expense.
17. To access self-help groups, advocacy services, and legal services at any time.
18. To receive an impartial review of alleged violations of rights.

**CLIENT RESPONSIBILITIES:**

As a client you are expected to follow the rules and regulations of the program. Failure to do so may lead to the termination of services. As a client, you are expected to:

1. Take responsibility for yourself and your behavior.
2. Take part in the formulation of, and abide by, your own treatment/rehabilitation plan.
3. Keep all appointments as scheduled. If you are unable to maintain an appointment, you are responsible for notifying the agency/counselor as soon as possible.
4. Respect the privacy, confidentiality and identity of other clients you may come in contact with.
5. Maintain respectful, non-destructive, non-violent conduct toward agency property, staff, and other clients you may come in contact with. Discrimination against staff or other clients based on race, religion, ethnicity, color, sex, sexual orientation, gender identity, national origin, age, disability, veteran status, family medical history, genetic information, or any other character protected by law will not be tolerated.
6. Present financial resource information (e.g. insurance, proof of income and residency) at the time of service and to honor copayments and billing statements.
7. Family involvement expectations: We encourage you to have other people who are important in your life involved in your treatment (family, friends, significant others). Be sure to sign Release of Information forms for family and friends to be able to participate in your treatment.

**RELEASE OR DISCHARGE FROM SERVICES:**

As a client you have the right to be discharged from services if you feel you no longer benefit from services or you have obtained your treatment and rehabilitation goals.

**CLIENT GRIEVANCE PROCEDURES:**

As a client, you have a right to express your opinion, recommendations, and complaints regarding abuse, neglect, or violation of rights. You may do so verbally or in writing to:

1. A staff member or the Executive Director of Beacon Mental Health.
2. The Chairperson of the Board of Directors of Beacon Mental Health.
3. Clients Rights Monitor, Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services, 1706 E. Elm St., Jefferson City, MO 65102, 1-800-364-9687.

I UNDERSTAND AND HAVE A COPY OF THESE RIGHTS. I AUTHORIZE BEACON MENTAL HEALTH TO PROVIDE MENTAL HEALTH TREATMENT TO ME AS DETERMINED CLINICALLY NECESSARY.

_____
Client Signature Date

_____
Guardian/Legal Representative Date

_____
Explained by (if applicable) Date

## CLIENT RIGHTS, PROGRAM INFORMATION & SERVICE AGREEMENT

**CLIENT NAME:** _____ **CLIENT ID:** _____