TRI-COUNTY MENTAL HEALTH SERVICES, INC.

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

CLIENT RIGHTS:
As a client of Tri-County Mental Health Services, Inc., (TCMHS) 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, martial status, gender, 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 TCMHS' 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, 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 TCMHS.
2. The Chairperson of the Board of Directors of TCMHS.
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 TRI-COUNTY MENTAL HEALTH SERVICES 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:** ____________