STATEMENT OF RIGHTS: A person who receives Behavioral Health Services has these rights:

- To be treated with consideration, respect, and dignity at all times.
- To receive timely and competent mental health services.
- To have equal access for treatment and services, regardless of income level, age, race, sex, national origin, religious affiliation, and type of presenting problem. Language barriers, cultural differences and cognitive deficits are taken into consideration and provisions are made to facilitate meaningful consumer participation.
- To have privacy when undertaking treatment.
- To maintain confidentiality of records and all information, unless released with written permission.
- To be fully informed about presenting problems, diagnosis, treatment plans, and to register acknowledgment of participation in formulating a treatment plan.
- To make choices about the length of treatment and participation in treatment and research activities.
- To be referred to other treatment providers if needed or dissatisfied with Department services.

Behavioral Health may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is not guardian or conservator, a designated person may seek to enforce these rights. As a provider we must protect and promote these rights.

THE INDIVIDUAL AND/OR FAMILY/SIGNIFICANT OTHER RESPONSIBILITIES:

1. The individual and/or family/significant other participates to the extent possible or desired in the development of treatment plan and subsequent changes.
2. The individual and/or family/significant other has responsibility to notify the department when scheduled visits can not be kept—preferably more than 24 hours in advance.
3. The individual and/or family/significant other has the responsibility for supplying accurate and complete information regarding medical history and mental health history.
4. The individual and/or family/significant other is responsible for his/her action if the treatment plan is not followed.
5. The individual and/or family/significant other is responsible to notify the department if instructions are not understood or cannot be followed.

QUESTIONS OR COMPLAINTS:

1. As your Behavioral Health provider, we strive to provide quality services. If you need assistance, have a question or complaint, please speak to your provider or a member of the Behavioral Health Staff. If you are not satisfied you may contact us at:

   Agency: Myrtue Medical Center Behavioral Health Department
   Address: 1303 Garfield Avenue Harlan, IA 51537
   Phone Number: 712-755-5056
2. If, in your view, discussion of the matter has not adequately resolved the issue, you may contact Kevin Kaminski, the Director of the Behavioral Health Department, in person, by phone or in writing. If, in your view, the matter has not been adequately resolved, you may appeal and voice a grievance to the CEO of Myrtue Medical Center in person, by phone or in writing. You should identify the issue, facts related to the issue, sign and date your written notice. The CEO shall respond within 30 days of receipt of the grievance.

3. If you are still dissatisfied with the appeal process, you may file a written appeal to the Board of Directors of Myrtue Medical Center. You should identify the issue, facts related to the matter, sign and date your written notice. The Board of Directors shall render the final decision. A decision shall be made at the first available meeting of the Board of Directors, after the written appeal is received by the Board.

**COPIES OF IMPORTANT FORMS AND INFORMATION:**

____ I have been offered a copy of the following forms and information. I have been provided a copy of the following forms if I requested one and did not refuse it. I have read all of the following information or had it explained to me. I understand it and have had a chance to have all of my questions answered.

- Behavioral Health Rights and Responsibilities including how to voice questions or complaints.
- Financial/Billing Information form
- Consent to Treatment
- Authorization to Release Health Care Information
- Notice of Health Information Practices

Date: __________________________ Signature: __________________________

Relationship if not signed by the individual:

___________________________________________________________________________________

Witness: ____________________________________________________________________________