

PENN BEHAVIORAL HEALTH MEMBER RIGHTS AND RESPONSIBILITIES

The following statements are provided as a general guide to your rights and responsibilities:

Members have the *right* to:

1. **Receive prompt, considerate and courteous care** with respect to your personal privacy and dignity.
2. **Be provided with information** about PENN Behavioral Health’s available health-care providers and services and how you can access them.
3. **Be informed about your own treatment plan** and prognosis, and to participate in decisions involving your care, which includes the right to consent to or refuse treatment. Except in emergencies, this information shall include a description of the treatment, the medically significant risks involved in each treatment or non-treatment, and the name of the person who will carry out the procedure or treatment. These rights apply to the person or guardian who may have legal responsibility to make decisions regarding medical care.
4. **Access emergency services** in a potentially life threatening situation without prior approval from your plan.
5. **Request to change your provider.**
6. **Timely access** to appropriate mental health/chemical dependency treatment in the least restrictive environment necessary, and remain free from unnecessary or excessive medication.
7. **Have your medical records kept confidential**, except when disclosures are required by law or with specific written permission.
8. Be fully advised and provided with an **informed consent for any experimental procedures**. You have the right to refuse to participate in an experimental procedure and no attempt will be made to influence you to give consent.
9. **Reasonable continuity of care**: to receive timely and appropriate discharge planning in the case of hospitalization, and be provided with appropriate guidance and recommendations for additional care when a course of treatment or coverage is terminated.
10. **Have all civil rights upheld**: To not be discriminated against in treatment services on the basis of age, race, ethnicity, gender, sexual orientation, education, handicap, or religion.
11. **Express a concern or grievance**. You may contact any PENN Behavior Health staff person to file a written or verbal complaint or the Department of Quality Improvement: 3535 Market Street, 4th Floor, Philadelphia, PA 19104, or call (888) 321-4433. All complaints will be responded to within 30 days of the date of receipt. All written complaints about the quality of care or services will be considered “grievances” and will be responded to within 5 business days from the date of receipt. You must include your name and subscriber identification number as well as the details of your concern or problem. You may also address grievances directly to your HMO.
12. **To be informed about your rights and responsibilities and to make recommendations** regarding them.

Members have the *responsibility* to:

1. **Provide accurate and complete information** concerning your present problem, past medical history, and other matters relating to your health so that PENN Behavioral Health may provide the best care for you.
2. **Participate** the most you can in understanding your problems and developing your treatment goals.
3. Make it known whether you clearly **understand your treatment plan** and what is expected of you.
4. **Follow the treatment plan** that you have agreed upon with your provider.
5. **Assume responsibility** for the consequences of your actions should you refuse treatment or not follow your treatment plan.
6. **Be considerate and respectful** of the rights of other clients, treating providers and office staff.
7. **Keep appointments** and notify your provider promptly if you are unable to come in.
8. **Assure that the financial obligations** of your care are fulfilled.

I agree to participate in an evaluation and course of treatment with a designated PENN Behavioral Health provider. By my signature below, I certify that my questions have been answered in full, and that I understand my rights and responsibilities and agree to abide by them.

I have: received a copy for my personal records, or declined a copy.

Signature of member, parent or guardian

Date

Signature of provider

Date