family service
counseling • support • compassion

Name _____

Date of Birth _____

Adult Consent for Mental Health Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by professional clinical staff from Family Service. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing and psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I am aware of this agency's fees which are also available for my review upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential record at Family Service and I consent to disclosure for use by Family Service staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

7. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

8. **If you believe you have been treated differently because of race, color, national origin, religion, sexual orientation, disability or age, you may file a discrimination complaint with the following agencies:**

Office for Civil Rights
Office of Justice Programs
U.S. Department of Justice
810 Seventh Street NW
Washington, DC 20531

Wisconsin Department of Justice
Office of Crime Victims Services
P.O. Box 7951
Madison, WI 53707-7951

Wisconsin Department of Justice
Contract Compliance Office
P.O. Box 7857
Madison, WI 53707-7857

I have read and understand the above, have had an opportunity to ask questions about this information and I consent to an evaluation and outpatient mental health treatment through the clinic based upon an assessment that determined appropriateness of outpatient treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider at any time about the above information or the treatment I am receiving.

_____ _____

Signature of client ages 18 years or older or legal representative **Date**