

Innervisions Counseling & Consulting Center S.C.

840 STATE ROAD 136, Suite 1 in Baraboo, WI 53913
231 East State Street in Mauston, WI 53948
Phone (608) 477-9858 Fax (877) 560-0578

INFORMED CONSENT FOR BEHAVIORAL HEALTH SERVICES for: _____

PLEASE READ AND SIGN BELOW:

Your comprehensive assessment was completed and it has been determined that you are appropriate to receive mental health outpatient services from the Innervisions Counseling & Consulting Center Outpatient Mental Health Clinic. The clinic wants you to be aware of your rights as a patient and requests your informed consent to treat you. Your signature below indicates that you have been explained, understand and you are in agreement with the following:

1. I have been explained the treatment alternatives.
2. I have been explained the possible treatment outcomes and side effects.
3. I have been explained the treatment recommendations.
4. The services, goals and duration of treatment will next be explained in my individualized treatment plan and reviewed regularly.
5. I have been given the clinic's patient rights statement.
6. I have been given the clinic's fee schedule, insurance and payment explanation.
7. I have been given the clinic's grievance procedure.
8. I have been given the clinic's phone number and explanation on how to receive emergency services when the clinic is closed.
9. I understand I could be involuntarily discharged by the clinic for violating clinic policy.
10. I understand that I can withdraw this consent in writing at any time.
11. I understand that this form will be reviewed annually and I can request a copy of my patient's rights, payment explanation, grievance procedure or discharge policy at any time.
12. If you need to cancel an appointment, Innervisions request a 24-48 hour notice or phone call.
13. We may look at your legal profile on CCAP to assist us with your continuity of care.
14. **Emergency On-Call Protocol:** After Hours service is available for clients from 4:30pm-8:30am. The After Hours number is (608)477-2708 and a clinician will return the call. The after hours number is also on the back of your appointment card.

Any additional information Innervisions wishes you as the patient to know:

Your treatment is a cooperative effort between you and your therapist. Please feel free to discuss any alternative treatment methods as well as possible consequences of stopping or not receiving treatment with your therapist.

This consent for treatment will remain in effect until treatment is terminated, but not longer than 12 months. You have the right to withdraw your consent for treatment at any time in writing. Please feel free to ask your therapist if you have any specific questions. We look forward to working with you and you can request a copy of any policy at any time.

Signature of minor age 14 years or older

Date

Signature of legal representative for minor

Date

Signature of witness

Date

Patient Signature

Date