Shorehaven BEHAVIORAL HEALTH, INC

CONSENT FOR TREATMENT

In order to consent to treatment for mental health concerns, you need to know the following. This document is for the patient *or* for the parent or guardian of a child patient, in which case assume the form refers to the child.

Informed Consent. You have the right to make an informed decision about entering into treatment. Your therapist's explanation of the treatment plan, & this form, & one of our brochures, “Helping You Find Your Strength and Serenity,” or “Preparation for AODA Counseling at Shorehaven,” give you details for your INFORMED CONSENT FOR TREATMENT.

Patient’s Rights. Please read the **Wisconsin statement of patient's rights** on the other side. Shorehaven clients have the right to request a consultation with the Clinic Administrator or a staff Consultant. The best care is provided by a team including the therapist and a Certified Supervisor, Psychiatrist, or Consulting Psychologist. I understand Shorehaven staff will usually consult with other skilled staff, as required by law, regarding the best treatment plan for my care.

Consent to Treatment. My signature below indicates my **voluntary consent for myself or my child to the treatment plan** described to me. If the client is a child, I attest I am the legal guardian of the child and have the right to consent to treatment for this child.

This consent applies to all providers at Shorehaven who may provide services to me and permits the sharing of information by my providers *within* Shorehaven. I understand that consent expires at the end of treatment and I have the right to withdraw this consent at any time I choose. I understand this consent is for treatment and does not include participation in research.

In case of an **emergency**, SBH reserves the right to administer medical treatment on the premises or contact and advise emergency personnel on the premises or at an emergency room regarding my needs at that time.

On the date indicated below, I have been informed of the following information regarding my treatment.

1. Shorehaven is licensed under DHS35 and DHS75. Services begin with assessment or evaluation by a treatment provider under state law DHS35 or DHS75 or a professional licensed under Statutes Chapter 440, 448, 455, or 457.
2. Diagnostic or psychological tests may be administered to help understand the best way to assist. From a diagnostic evaluation of the problem, appropriate recommendations will be provided.
3. *Type* of treatment to be provided
4. The expected *Goals or Benefits* of the treatment
5. Any *alternative treatments* available
6. Possible *Risks* associated with the treatment, if any, and possible risks from not receiving this care
7. Estimated *Frequency* and *Duration* of the treatment
8. Estimated *Cost* of treatment & my ultimate responsibility for costs
9. The *Provider of* treatment and his or her credentials
10. Procedures to follow in an *Emergency*.
11. My right to a *second opinion, or a consultation with a supervisor or staff consultant*. (You will be assisted in obtaining a second opinion if you so choose.) Information about consultants or my therapist's supervisor, who is available if I have a question/complaint, will be given upon request.

Hours of Operation. SBH is open Monday through Thursday 9:00AM to 9:00PM, Friday 9:00AM to 5:00PM, Saturday 9:00AM to 4:00PM. Counselors may see clients before 9:00AM. or on weekends. Day Treatment is weekdays between 10:00 and 3:00.

Limits to Confidentiality. The information given in therapy is **confidential** and will only be released outside of Shorehaven with your written permission (or with the permission of a parent or guardian of a minor). Disclosures. However, under **Wisconsin & Federal Statutes, *confidentiality has limits.***

_______ I acknowledge these limitations: a) The therapist may use information within SBH and with its business associates for treatment, payment, and other health care operations. b) The therapist is usually *required* to consult with clinical supervisors in order to provide a high quality of care, to answer certain subpoenas or court orders, to report threats of homicide or suicide, to report *the suspicion of child abuse or child neglect,* and may report elder abuse or abuse of a handicapped person or a crime which may occur in the future. c) The therapist may report physical assaults or crimes which occur on the clinic premises.

Child welfare agencies are considered agents of the Children’s Court and may request our office notes if a child is in Safety Services or protective services.

-Please see the reverse side, check the boxes, and sign the consent form. Thank you.

Limited Disclosures. All disclosures will be made to the appropriate parties, such as authorities, parents, or intended victims of violence. When the therapist must release information *without* your consent, the information revealed will be limited to what is necessary to protect you or to protect others, or the limited information necessary for collection of a past due bill, or the information ordered to be released to the court.

When information is released *with* your consent, we will release the information you request us to disclose.

Certain information is Privileged; your therapist can explain.

***IMPORTANT*: PLEASE COMPLETE THESE INSTRUCTIONS FOR CONTACTING YOU:**

□Y □N Shorehaven may MAIL appointment reminders and other correspondence regarding appointments and services.

□Y □N Shorehaven may EMAIL me appointment reminders and other correspondence regarding appointments and services. EMAIL: ____

□Y □N In compliance with state regulations, Shorehaven may send me a Follow Up questionnaire and satisfaction survey

When Shorehaven may call me regarding appointments, confirmations, etc., we will leave messages with persons you designate or follow your restrictions (please explain):____

☐ If this box is checked, I am aware my psychotherapist is either an intern or student practicing under supervision.

☐ If this box is checked, my psychotherapist is practicing under the supervision of a provider in my insurance network. I have been informed and consent to treatment by this therapist.

This consent applies continuously throughout my services unless revoked in writing.

Signature:____ Date:____/____/_______

(Patient, or parent or guardian if patient is a minor)

Signature:____ Date:____/____/_______

(Spouse or child 14 years or older if child is the patient)

The client was given oral explanation of this consent, of the limits to confidentiality, client's rights, the treatment plan, the payment plan. A copy of the **PAYMENT PLAN FORM AND CONSENT FORM HANDOUT,** which includes the text of this Consent, was given to the client. Therapist's Signature: ____ Date:____/____/____

Wisconsin Bill of Patient's Rights

These rights apply to inpatient and involuntary patients as well as outpatients. Many of the rights, therefore, may not be completely relevant to your outpatient therapy experience. These rights are found in Ch 51.61 Wisconsin Statutes.

Treatment: * To receive prompt and adequate treatment. * To have conditions placed upon you that are the least restrictive of your freedom (except patients under ss. 51.35, 51.37, 971, 975). * To refuse treatment and medications before commitment or because of religious prohibition, and, if you are a voluntary patient, to refuse any treatment. * To be free from unnecessary or excessive medication at any time and to refuse drastic treatment or experimental research. * To be free from isolation and restraint except as a part of a treatment program or in emergencies when you pose a danger to others or yourself.

Access to Courts: * To be considered legally competent, unless otherwise determined by a court, to make your own decisions -- such as marriage, voting, and making a will. (Sec. 51.59 Statutes). * To bring legal action for damages against those who violate your rights.

Privacy Rights: * To refuse to be filmed or taped without your consent (except in maximum security units where cameras monitor common areas). * To pursue the religious worship of your choice. * To have your treatment records and conversations about your treatment kept confidential except as provided by law (Sec. 51.30, Statutes). * To have access to your treatment record after discharge (or during treatment if the facility director approves it) and to have access at all times to records of medications you take or treatment you receive for physical health reasons.

Right to Complain: * If you feel your rights have been violated, you have the right to use a grievance procedure. Contact your Complaint Investigator to file a complaint or learn more about the grievance procedure. Grievance Officer for Shorehaven: Don D. Rosenberg, 3900 W. Brown Deer Rd., Suite 200, Brown Deer, WI 53209, 414-540-2170 X234. If you are dissatisfied with the resolution of your Grievance, you will be advised on taking a grievance to the Department of Health and Services.