Consent for Treatment

Instructions: In order to consent to mental health treatment, you need to know the following information. This document is for the patient or for the parent/guardian of a minor. Please complete this entire section.

☐ **Yes** ☐ **No**	Shorehaven may CALL with appointment reminders and other information regarding appointments and services at the following number: _____.
☐ **Yes** ☐ **No**	Shorehaven may TEXT me regarding appointment times and reminders at the following number: _____. (Standard messaging rates may apply.)
☐ **Yes** ☐ **No**	Shorehaven may EMAIL me appointment reminders and other correspondence regarding appointments and services at the following address: _____.
_____ **(Initials)**	Your initials here permit Shorehaven to send prescriptions electronically to the pharmacy of your choice.
☐ **Yes** ☐ **No**	In order to check for drug interactions and to provide the highest quality of care, Shorehaven may access my record of medication prescriptions, including non-psychiatric medications.

☐ If this box is checked, I am aware that my therapist is either an intern/student under supervision.

☐ If this box is checked, my therapist is practicing under the supervision of a provider in my insurance.

Informed Consent. I understand I have the right to make an informed decision about treatment. A Shorehaven therapist explained the treatment plan and give me a brochure, "Helping You Find Your Strength and Serenity," and/or "Preparation for AODA Counseling at Shorehaven."

Patient's Rights. In addition to the Wisconsin Statement of Patient's Rights, you have the right to request a consultation with the Clinic Administrator or a Supervisor. The best care is provided by a team including the therapist and a Clinical Supervisor, Psychiatrist, or Consulting Psychologist. I understand Shorehaven therapists will usually consult with other skilled staff, as required by law, regarding the best treatment plan for my care.

Voluntary, Informed Consent to Treatment. My signature below indicates voluntary consent for the treatment plan for myself or, if the client is my child, for that child and the family. 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 and permits the sharing of information amongst Shorehaven staff.

Duration of Consent. I understand that consent expires after 15 months and I have the right to withdraw this consent in writing at any time. I understand this consent is for treatment and does not include participation in research.

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

PLEASE TURN OVER TO SIGN

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

1. Shorehaven is licensed under DHS35 and DHS75. Services begin with assessment/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 treatment plan. After a diagnostic evaluation of the problem, appropriate recommendations will be provided.
3. The treatment plan includes the type of treatment along with the expected goals or benefits of the treatment.
4. The treatment plan includes estimated *frequency* & *duration* of treatment and any *alternative treatments* available.
5. I was informed about possible *risks* associated with the treatment and possible *risks* from not receiving this care.
6. I was informed about the estimated *cost* of treatment & my ultimate responsibility for costs.
7. I was informed about the *provider of* treatment and his or her credentials.
8. I was informed about the procedures to follow in an *emergency*.
9. I understand I have a right to a *second opinion or a consultation with a supervisor or staff consultant*.

Hours of Operation. SBH is open Monday through Thursday 8:00 AM to 8:00 PM, Friday 8:00 AM to 5:00 PM, Saturday by appointment only. Therapists may see clients outside of the standard hours.

Limits to Confidentiality. The information I give in therapy is generally confidential and will only be released outside of Shorehaven with my written permission (or with the permission of a parent or guardian of a minor). However, I acknowledge these limits to confidentiality under Wisconsin & Federal Statutes: 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.

Limited Disclosures. All disclosures will be made to the appropriate parties as directed by law, such as authorities, parents of minors, 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.

Informed Consent. I received an explanation of this consent, the limits of confidentiality, the proposed treatment plan, and the payment plan. I received a copy of the information in this form, Shorehaven's HIPAA Privacy Notice, and the brochure "Helping You Find Your Strength and Serenity." I consent to the planned treatment.

Client if 14 or older:

_____	_____	_____
Print Name	Signature	Date

Parent or Legal Guardian:

_____	_____	_____
Print Name	Signature	Date

The client was given oral explanation of this consent, the limits to confidentiality, client's rights, the treatment plan, and the payment plan. A copy of the **PAYMENT PLAN & CONSENT FORM HANDOUT,** which includes the text of this Consent, the Wisconsin Bill of Patient's Rights, and the brochure "Helping You Find Your Strength and Serenity," was given to the client.

_____	_____
Therapist Signature	Date