Shorehaven BEHAVIORAL HEALTH, INC (SBH)

CONSENT FOR TREATMENT

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 child patient.

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

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

□Y □N Shorehaven may TEXT me regarding appointment times and reminders at #_____. Remember, there could be charges for text messages.

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

□Y □N In compliance with state regulations, Shorehaven may send me a follow-up questionnaire & satisfaction survey

*When Shorehaven staff may call regarding appointments or confirmations, they will leave messages with persons I designate or will follow these 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.

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** on the other side of this form, Shorehaven clients 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 SBH 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.

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 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 treat the problems. From a diagnostic evaluation of the problem, appropriate recommendations will be provided.

-There is important information on the reverse. Please check sign and date this consent form. Thank you.

3. The treatment plan includes the type of treatment along with the expected goals or benefits of the treatment.
4. The treatment plan includes the estimated *frequency* and *duration* of the treatment and any *alternative treatments* available.
5. I was informed about possible *risks* associated with the treatment, if any, 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 8:30AM to 8:00PM, Friday 8:30AM to 5:00PM, Saturday 9:00AM to 3:00PM. Counselors 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.

Print Name of Patient:_____

Signature:_____ Date:____/____/_____
(Patient if 14 years old or older)

Print Name of Parent/Guardian:_____

Signature:_____ Date:____/____/_____
(Parent/guardian if patient is a minor)

Print Name of Spouse/Significant Other:_____

Signature:_____ Date:____/____/_____
(For couples counseling, spouse or significant other)

The client was given oral explanation of this consent, of the limits to confidentiality, client's rights, the treatment plan, and the payment plan. A copy of the **PAYMENT PLAN FORM AND 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's Signature: _____ Date:____/____/____