Clients Rights and Informed Consent

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As a consumer of mental health services you have the option to engage in a therapeutic relationship with the provider and have rights and responsibilities if you choose to enter into this relationship.

1. **ENGAGING IN A THERAPEUTIC RELATIONSHIP**: The purpose of mental health services is to help alleviate the problems and symptoms that you present for the focus of psychotherapy. If there are expected side effects from psychotherapy, or consequences of NOT receiving or ending services, they will also be discussed with you. If alternative treatment modes may be appropriate, they will be addressed and appropriate referrals will be made.
    a. **LIMITS TO THERAPEUTIC RELATIONSHIP:** There is no on-call service associated with this therapeutic relationship. Every effort will be made to respond to emails or voicemails within a timely manner, during business hours. If you experience significant distress or a mental health emergency, please call 911 or visit your nearest emergency department.

2. **CONFIDENTIALITY**: The content of all sessions, telephone contacts, e-mails, texts and authorized contact with others will be held confidential and cannot be disclosed without your consent. All contacts made about you will occur after an authorization for release of information is signed, or with verbal approval if a signature cannot be obtained to allow for timely release of information. Your identity and confidential information may be disclosed without your consent if it is determined that you present a risk to yourself or others. Licensed mental health providers are mandatory reporters under Wisconsin statutes and confidential information may be disclosed if there is reason to believe a consumer is a risk of harm to themselves or another person. The degree of risk to self or others will dictate whether confidential information is disclosed without consent of the consumer.

    a. **ELECTRONIC COMMUNICATION**: Email and phone texts may not be completely secure or confidential. If you choose to communicate with me by these methods, be aware that all emails and texts are retained in the logs of your and my service providers. Please be aware this also applies to any emails or texts sent between me, you, and collateral contacts (ex: family members and other service providers). While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should also know that any emails or texts I receive from you and any responses that I send to you become a part of your legal record. Please be advised that efforts will be made to encrypt emails that contain Protected Health Information but there is no guarantee of electronic breach by outside entities. Text messages are not encrypted so you may want text communication to be general in nature. If you prefer to avoid electronic communication, please use the phone to contact me.

3. **INVOLUNTARY DISCHARGE**: A client may be discharged from treatment when the safety of the clinician or other clients is at risk. A client shall be discharged from treatment when any of the following occur: the client verbally threatens a clinician, the client is responsible for theft or damage to the building/property at which the office is housed or the belongings of the clinician, the client displays chronic harm or threats to harm self or others and is not in compliance with a treatment or safety plan developed collaboratively with the clinician, the client is unable to pay for treatment. The client shall be notified in writing of the reason for discharge, the effective date of discharge, and resources available to the client for further treatment.

Your signature below indicates that you are giving consent to participate in psychotherapy and/or case management and that you understand the information presented above. You have the right to withdraw informed consent at any time in writing.This consent will remain valid until it is revoked or until the therapeutic relationship ends.

- ❏ I would like more information about privacy practices, confidentiality and its limits, risks, or HIPAA.
- ❏ I do not need any additional information at this time. I understand I can ask for more information at any time.

Signature:_____ **Date:**_____

Please Print Name: _____