Peace of Mind Counseling

Informed Consent Notice

Risks and benefits:
When receiving treatment for mental health problems there are both risks and benefits. Risks or side effects may include discomfort from sharing personal information, or discomfort from trying/applying treatment strategies to your daily living routine. There may also be times of strong unpleasant feelings. This is a normal part of the counseling process and can be discussed with your therapist at any time.

There are also clear possible benefits. Benefits may include: increase in ability to cope with stressors, a decrease in mental health symptoms, better relationships, increased self-understanding and acceptance, and an overall feeling of being understood and unconditionally accepted. In short, you may feel better and get along with people better.

As a client or guardian of a client, you have numerous rights (see next page). You have the right to refuse or decline any proposed treatment methods or services. However, your refusal may result in, among others, symptoms or problems intensifying or becoming chronic, or symptom relief may take longer to achieve.

Confidentiality:
During the course of serving you, Peace of Mind Counseling may find it necessary to share information with other health care or business associates. Reasons we might share information include:

- Use of a billing service to receive payment *
- Health insurance requests for information *

*Your permission is granted if you sign our intake form

- Therapists who are receiving supervision will consult with Supervisor as required. Licensed therapists will engage in peer review or professional collaboration to ensure you are receiving high quality care

Confidentiality of your information will be disclosed <u>without your consent</u> in these instances:

- In certain situations involving suicide or threatening another person's life
- The possibility of abuse or neglect of a child or vulnerable adult
- Court ordered release of records

Peace of Mind Counseling adheres to all Federal, State, and local laws and regulations regarding Privacy Practices. Any disclosures of information other than those listed above including sharing information with your other care providers) will only be released with your written authorization. You may revoke that authorization at any time in writing.

Treatment:
On the first day, you will be asked to fill out forms that provide us with your personal demographic information as well as why you are seeking treatment, symptoms, and other questions about your past and present that inform us in an effort to provide you with best care. You may also be asked questions regarding your family, current or past relationships, previous counseling, medications, and more. This information will be kept confidential as described above.

Generally you will receive a diagnosis at the first session, which allows the therapist to develop a treatment plan with you. Your therapist will discuss treatment approaches to address your symptoms or struggles. Treatment approaches used within this agency include, but are not limited to, Cognitive-Behavioral Therapy, Choice Theory, Relaxation/Anxiety Reduction, Play Therapy, and Family Therapy. It may take time and several strategies to find the best method for you as an individual. Discussing your goals and strategies/options is an important part of your active participation in the counseling process.

Summary of Client Rights: *All consumers of outpatient mental health services are guaranteed the following rights under Wisconsin State law:*

- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status.
- The right to the least restrictive treatment conditions necessary.
- The right to receive prompt and adequate treatment.
- The right to be free from any unnecessary or excessive medications at any time.
- The right to be informed of your treatment and care and to participate in the planning of your treatment and care.
- The right to a humane psychological and physical environment.
- The right to confidentiality of all treatment records, to review and copy certain records, and to challenge the accuracy, completeness, timeliness or relevance of information in your records in accordance with the provisions of DHS35.
- Be informed about the costs of treatment.
- The right to file a grievance about violation of these rights without fear of retribution.
- The right to go to court if you believe that your rights were violated.
- The right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.

Source: Ch. 51 Wisconsin Statutes

You have also received a client rights brochure which explains your rights more completely and lists persons to contact if you have a complaint or grievance.

Consent:

I have read and understood the policies and confidentiality exceptions described herein. I am requesting professional services from Peace of Mind Counseling. I understand that I can ask questions or discuss concerns at any time regarding my treatment with my counselor or their supervisor. I also understand I may terminate counseling or withdraw this consent at any time for any reason, but the withdrawal must be in writing and signed by me or my legal guardian.
and
I have been informed of my rights as a client and given the opportunity to ask questions.

Client Name (print) _____

Client Signature (if age 14 or over) _____ *Date* _____

Parent or Guardian signature (if relevant) _____ *Date* _____

Therapist Signature _____ *Date* _____