Actively Engaging in your Journey of Creating Balance LLC

Informed Consent for Treatment

Name: _____

Date of Birth: _____

1. Consent to Evaluate/Treat: I voluntarily consent that I will or I voluntarily consent that my minor child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from *Creating Balance LLC*. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a M.A. Licensed psychotherapist. Recommendations may include further evaluation by a licensed Psychiatrist or Psychologist. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. Possible risks of treatment include intense feelings when discussing life issues with therapist. Disengaging from treatment or not fully participating in treatment consistently may result in the issues worsening.

3. Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. Confidentiality, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at *Creating Balance LLC*, and I consent to disclosure for use by *Creating Balance LLC* staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician. Involuntary discharge may take place if there is a failure to follow through with treatment recommendations.

6. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____ _____
Signature of legal guardian for minor under age 18 Date Relationship to Client

_____ _____
Signature of client ages 14 years or older Date

_____ _____
Signature of witness Date