

Central Wisconsin Mental Health Associates, SC

Adult Outpatient Consent and Acknowledgment

I, _____, hereby acknowledge that I have received and have been given an (print name)

opportunity to read a copy of CWMHA’s statement of consumer rights, limits of confidentiality, no show/ cancellation policy, privacy policy, and grievance process. This certifies that I give Central Wisconsin Mental Health Associates, SC permission to provide evaluation and/ or psychotherapy treatment to myself. I understand that I am expected to benefit from treatment, but there are no guarantees. Maximum benefits will occur with regular attendance, but I understand that I may feel temporarily worse while in treatment. I understand that if I have any questions regarding the notice or my privacy rights, I can contact CWMHA, attention Privacy Officer at 715-317-5713 or email at admin@CWMHA.org. I understand that this consent can be withdrawn from me at any time, and that I am entitled to a copy of this consent at any time.

Benefits or expected outcome of proposed treatment include but are not limited to:

- Improvement of presenting condition or symptoms
- Improved ability to cope with developing life demands
- Improved communication skills.

Possible effects of receiving treatment include but aren’t limited to:

- The client may improve functioning
- The presenting condition may remain unchanged or worsen or a new problem may develop
- The client may become too dependent on treatment.

Possible effects of not receiving proposed treatment include but are not limited to:

- Symptoms disappearing spontaneously or from other interventions (education, self-help, etc.)
- The presenting condition may remain unchanged, worsen or new problems may develop
- Client may be at risk for injury to self or others.

Alternate treatment modalities include but are not limited to:

- Self-help groups, environmental changes, inpatient services and community resources such as church, social services, criminal justice system and other agencies.

I additionally consent to communications via (initial next to communication type)

_____ Phone Calls

Preferred Phone Number _____ Permission to leave message ____ Yes ____ No

Alternate Phone Number _____ Permission to leave message ____ Yes ____ No

_____ Email

The ability to respond to e-mail communication initiated by you. It is not our practice to send e-mails or put you on a list serve. However, if you e-mail us, your permission is required to reply. Emails are NOT encrypted or secure.

_____ (e-mail address required, if yes. Please print clearly.)

Signature of Consumer (if over 14 years old) Date

Signature of Guardian Date

Signature of Witness Date

This consent is valid for 15 months from the date of the signature.