



## Compass Behavioral Health Clinic

1820 Center Avenue · Janesville, Wisconsin 53546

Phone: 608 755-1475 Fax: 608 755-1733

### Informed Consent for Treatment

I understand that my formal admission into Compass Behavioral Health Clinic is conditioned upon my consent to participate in the proposed treatment services. I have spoken with a counselor/therapist and the prescribed treatment has been explained to me. I have been told and do understand the following points:

- That benefits of being a recipient of Compass Behavioral Clinic services may include, but are not limited to, substance abuse and mental health rehabilitation and improved psychological, physiological, social, and occupational functioning.
- That services provided may include assessment, case management, urinalysis, crisis intervention, group therapy, individual therapy, family therapy, and medication therapy.
- That risks of receiving Compass Behavioral Health Clinic services may include feelings of anxiety, frustration, depression, loneliness, helplessness or other intense emotions when life experiences or problems are discussed.
- That if a referral is made for medication evaluation, the psychiatrist/prescriber will discuss the side effects and benefits of any medications prescribed. Medications may be refused unless there is a court order.
- That Compass Behavioral Health Clinic treatment staff may recommend alternative treatment services and/or referrals to auxiliary services when appropriate or necessary.
- That refusal to participate in the proposed treatment services may result in additional and/or worse problems.
- That consumer's rights have been explained, that they are protected by statute and that they may only be denied under certain circumstances:
  - When there is reason to believe that there is a significant risk of harm to the life or health of myself or others.
  - Suspected cases of child neglect or abuse (S.48.98).
  - A lawful order of a court of jurisdiction.
- That my individual treatment needs will be evaluated and that I will be expected to actively participate in the evaluation process, treatment planning and the fulfillment of my treatment goals.
- That the cost of treatment services has been explained to me and I understand my financial responsibilities for services rendered.
- That this informed consent is effective for fifteen (15) months from the date the consent is given or until formal discharge from Compass Behavioral Health Clinic, whichever is sooner.
- That I have the right to withdraw this informed consent, in writing, at any time.

By my signature below, I attest that my rights have been explained to me, that I have received a copy of the Patient's Rights and Grievance Procedure and that I have given this consent for treatment voluntarily.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CBHC Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_