PRAIRIE COUNSELING SERVICES
1460 W. Main Street, Sun Prairie, WI53590

ANNUAL CLIENT RIGHTS/CONSENT FORM

PLEASE READ AND SIGN BELOW:

Prairie Counseling Services, according to the Department of Health and Social Services document HSS 35.18, want you to be aware of your rights as a client and ask for your informed consent to receive treatment.

I have received a copy of the "Client Rights and the Grievance Procedure for Community Services" brochure, the "Notice of Privacy Practices" handout and the "Client Financial Responsibility Form". _____**(Initial here)**

The following is some general information about the treatment process:

A) I have been explained any treatment recommendations which may include psychotherapy and/or the use of medications. Psychotherapy is conducted in sessions between the therapist and client talking about problems presented. If medications are a consideration they will be prescribed and monitored by a psychiatrist.
B) The services, goals and duration of treatment will be explained in an individualized treatment plan and reviewed regularly.
C) Any treatment has possible risks or side effects. These will be discussed with you. All medications have the possibility of some risks and side effects. If medications are prescribed, the expected or possible risks and side effects will be explained and a separate consent form for each medication will be signed.
D) The clinician will-suggest alternative treatment modes and make referrals or seek consultation when appropriate or necessary. If medications are considered, alternative medications and/or doses will be discussed.
E) The probable consequences of not receiving treatment, including not taking recommended medications, will be discussed.
F) You have the right to refuse therapy/treatment.
G) Informed consent is given for the duration of treatment but not for longer than one year. This form will be reviewed annually.
H) You have the right to withdraw informed consent at any time, in writing.
I) You may be involuntarily discharged by the clinic for violating clinic policy. A copy of clinic policies is available upon request.
J) I have been given the clinic's phone number and an explanation on how to receive emergency services when the clinic is closed.

If you have specific questions, please ask your treatment professional. We look forward to working with you.

_____ _____
Client Signature (over 14 years old) Date

_____ _____
Parent/Guardian Signature (for all clients under 14) Date

_____ _____
Witness Signature (if needed) Date