 **RETRAC Mental Health Clinic and Community Center**

**Informed Consent for Outpatient Mental Health Services (Revised: 12/2023)**

**The Clinic wants you to be aware of your rights as a consumer and requests your informed consent to received treatment:**

1. **I will participate in an assessment with a mental health professional to determine if I am appropriate for ongoing mental health services at the Clinic. Upon completion of the assessment, I understand that I will be provided with the following information:**

* **An explanation of the treatment being recommended, including specific services, possible goals, the expected duration, and the desired outcome**
* **An explanation of the possible benefits and side effects/risks of the recommended treatment**
* **An explanation of treatment alternatives, modes and services**
* **Possible consequences of not receiving treatment**

1. **I have been given a copy and explained orally my rights under 51.61, Wis. Stats. and DHS 94, Wis. Administrative Code.**
2. **I have been given a copy and explained orally the Clinic’s Privacy Practices related to HIPAA.**
3. **I have been given the Clinic’s fee schedule, insurance, and payment explanations.**
4. **I have been given a copy and explained orally the Clinic’s grievance procedure.**
5. **I have been given the clinic’s phone number, business hours and how I can obtain emergency mental health services during periods outside the normal operational hours of the Clinic.**
6. **I have been given a copy of the Clinic’s discharge policy and understand that I may be discharged involuntarily for such incidents as an inability to pay for services, displaying unsafe behaviors, or violating other Clinic policy.**

**This informed consent for treatment will remain in effect until treatment is terminated but no longer than 15 months from the time consent is given. The informed consent for treatment may be withdrawn at any time in writing by your or your guardian.**

**I have read, been given an oral explanation and understand the above and had an opportunity to ask questions about this information. I consent to receiving outpatient mental health services with the understanding that I have the right to ask questions of my treatment provider about the above information at any time.**

**Printed Name of Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature of Consumer Date**

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**Signature of Guardian Date**