COUNSELING SOLUTIONS, LLC 725 HEARTLAND TRAIL MADISON, WI 53517

Client's Rights and Informed Consent

Please read below and sign

Consistent with HFS 94, Wisconsin Administrative Code, Counseling Solutions, LLC, wants you to be aware of your right as a client and asks for your informed consent to receive treatment. Included with this form is a pamphlet explaining your rights and the grievance procedure available to you. Please read and keep it with your records.

The following are general points of information about the therapy process and treatment.

- The purpose of therapy is to help alleviate the problems and symptoms that you present.
- Therapy is conducted in sessions between you and your counselor talking about the problems presented.
- If there are any expected side effects from therapy, they will be discussed with you.
- Your counselor will suggest alternative treatment modes and assist in referrals when appropriate and necessary.
- The possible consequences of not receiving therapy or ending therapy will be discussed.
- The content of all sessions will be held confidential and can be disclosed outside this program only with your signed approval unless a specific statutory exception applies or a duty to warn exists.
- Your signature below indicates that you are giving consent to participate in therapy sessions and you understand your rights.
- You have the right to withdraw informed consent at any time in writing. Otherwise, this consent will be valid for one year, (12 months).

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

I have read the above information and have been notified of my rights and grievance procedure available to me. I hereby give my informed consent to receive treatment. I have also been advised of the cost of treatment.

Client Signature _____ Date _____

Please Print Name _____

Guardian (if applicable) _____ Print Name _____