



# MIDWEST CENTER FOR PSYCHOTHERAPY & SEX THERAPY

6300 University Avenue • Suite 125 • Middleton, WI 53562 • (P) 608-237-8000 • (F) 608-237-8005 • www.midwestcentertherapy.com

## INFORMED CONSENT FORM

**NAME OF CLIENT:** \_\_\_\_\_

I have been provided information regarding psychotherapy treatment and understand that I have the right to additional information concerning the following:

- a) the duration of treatment, to be discussed during treatment planning;
- b) benefits of treatment;
- c) administration of treatment;
- d) side effects of treatment;
- e) alternative of treatment modes;
- f) consequences of not receiving proposed treatment;
- g) consent effective for 15 months from date of signature;
- h) right to withdraw informed consent;
- i) I understand MCPST will bill me and my insurance provider as a service, but I am responsible for full payment of the bill. I understand in the event I do not pay my bill, my account could be referred to a collection agency, which could lead to legal action; and
- j) MCPST maintains the right to involuntarily discharge a client as determined by each therapist, under the Involuntary Termination Policy.

In addition, I have been informed orally of and been given access to a written copy of the Client's Bill of Rights.

\_\_\_\_\_  
Signature of Client(s)

**OR**

\_\_\_\_\_  
Person Authorized by Client\*

**AND**

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\*Person authorized by the client means the parent, guardian or legal custodian of a minor client or a client adjudged incompetent; the spouse or personal representative of a deceased client; and/or any person authorized by the client (this authorization must be in writing, witnessed and dated).