



# MIDWEST CENTER FOR PSYCHOTHERAPY & SEX THERAPY

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## CLIENT RIGHTS AND INFORMED CONSENT

**Client name:** \_\_\_\_\_

Consistent with HFS 94, Wisconsin Administrative Code, Midwest Center for Psychotherapy and Sex Therapy wants you to be aware of your rights as a client and ask for your informed consent to receive treatment. You have also been given information about rights to privacy. Our grievance procedure is available on request.

### **The following are general points of information about the therapy process:**

- The purpose of therapy is to help alleviate the problems and symptoms with which you present.
- During therapy you and your therapist will discuss the problems you have identified.
- Any potential side effects from therapy will be discussed with you.
- Your therapist will suggest alternative treatment modes and assist in referrals when appropriate and necessary.
- The possible consequences of not receiving therapy or of prematurely ending therapy can be discussed.
- The content of all sessions will be held confidential and can be disclosed outside the clinic only with your signed approval unless a specific statutory exception applies or a duty to warn exists. On occasion your therapist may consult with other therapists within the clinic.
- If you are being seen as part of a couple or family, there is the possibility that information from the chart will not be released unless all adult members sign the appropriate release forms.
- Your signature below indicates that you are giving consent to participate in therapy sessions and that you understand your rights.
- This consent will be valid for 15 months. You have the right to withdraw informed consent at any time. The request must be in writing.
- Midwest Center for Psychotherapy and Sex Therapy maintains the right to involuntarily discharge a client from therapy under the Involuntary Termination Policy.
- Please ask your therapist if you have any specific questions.

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

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

Guardian\* (where applicable) \_\_\_\_\_ Date \_\_\_\_\_

Print guardian name \_\_\_\_\_

\*Guardian means the parent, or legal custodian of a minor client and /or any person authorized by the client (this authorization must be in writing, witnessed and dated).