Restoring Balance Counseling, LLC

Client Rights and Informed Consent

Restoring Balance Counseling, LLC is required to inform you of your rights as a consumer of psychotherapy, per State of Wisconsin Department of Health Services Chapter 35 and HFS 94, Wisconsin Administrative Code. Information about your rights, the clinic grievance procedure, and the name and telephone number of the clinic's Client Rights Specialist has been provided to you.

Restoring Balance Counseling, LLC provides you with the following general information about the clinic, your treatment, and your rights as a consumer of mental health treatment.

1. The purpose of psychotherapy is to help alleviate the problems and symptoms that you present for the focus of psychotherapy.

2. Your psychotherapist will discuss the results of the assessment that is conducted. You and your psychotherapist will develop a treatment plan, which will include approximate duration of treatment, how treatment will be conducted and the desired outcome of treatment.

3. Psychotherapy is conducted in sessions between you and your therapist talking about the problems presented. Psychotherapy may be conducted individually, with family or in a group.

4. Your therapist will discuss alternative treatment modes with you, and assist in making referrals when appropriate and necessary.

5. The possible consequences of not receiving psychotherapy or of ending psychotherapy will be discussed with you.

6. The content of all sessions, telephone contacts, and authorized contact with others will be held confidential and cannot be disclosed outside of Restoring Balance Counseling, LCC without your consent. All contacts made about you will occur after an authorization for release of information is signed, or with verbal approval, if a signature cannot be obtained to allow for timely release of information. Clinical records are subject to review by your insurance company/authorized personnel or representative on their behalf. Client information is also shared with RBC, LLC staff to ensure emergency services are readily available to you.

7. Your identity and confidential information may be disclosed without your consent if it is determined that you present a risk to yourself or others. RBC, LLC staff are mandatory reporters under Wisconsin statutes and confidential information may be disclosed if there is reason to believe a consumer is at risk of harm to themselves or another person. The safety of consumers and staff will dictate whether confidential information is disclosed without consent of the consumer.

8. Fees for psychotherapy will be discussed with you and a fee agreement will be developed with you and your therapist. The fee agreement will be updated when there are changes in fees or coverage by a third party, or changes in your personal responsibility for treatment.

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9. RBC, LLC has a grievance procedure which your therapist will discuss with you. You will also be given a brochure outlining the clinic grievance procedure and the options available to you to file a grievance with the state of Wisconsin.

10. RBC, LLC maintains 1 emergency number to be used for consumers who are experiencing a mental health emergency. It is 608-577-3299. This number is also available on the clinic telephone messages. Additional instructions for emergency situations may also be present on the voicemail.

11. RBC, LLC maintains a policy for the involuntary discharge of consumers. This policy will be given to you at the time of admission for treatment.

Restoring Balance Counseling, LLC is required to obtain your consent for treatment. Your signature below indicates that you are giving consent to participate in psychotherapy and that you understand the information presented above. You have the right to withdraw informed consent at any time in writing. This consent will be valid for one year.

(2 initials requested)
I have read the above information and have been notified of my rights and the grievance procedure. I have received or been offered a copy of RBC, LLC Client Rights brochure (____) and the policy for Discharge from treatment (____).

I give my consent to receive psychotherapy treatment.

Signature of consumer _____ **Date** _____
(14 and older)

Please print name _____

Signature of Guardian _____ **Date**_____

Please print name _____

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