



Credence Therapy Associates  
1 ½ West Geneva St  
Elkhorn, WI 53121  
(262)723-3424

Consent to Treatment

Client Name: \_\_\_\_\_

Client: \_\_\_\_\_

Date of Birth      Current Age

Therapist: \_\_\_\_\_

Please read the following statements and provide your initials or signature where indicated agreeing that you did review this and understand its contents. If you have any questions, please ask your therapist or any of the office staff to assist you. You will also be given a copy of this document upon request

***If the patient is age 18 or over, patient signatures only (bottom);***

***If the patient is age 13 to 17, patient initials (items #12, 13, 14), and patient/parent signatures (bottom);***

***If patient is age 12 or under, parent signatures only (bottom).***

***Therapy is voluntary and you must consent to participate/have your child participate in counseling/therapy with the listed therapist.***

*I have been informed about the below issues:*

1. ***Treatment alternatives***, including other locations to get treatment, other modalities (individual/group/family) and the no treatment option.
2. ***Treatment recommendations and benefits*** of treatment including decreases in symptoms, improved cognitive or school related functioning, health status, quality of life, and awareness of your child's strengths and challenges.
3. ***Possible risks*** associated with treatment including disruption in daily life that can occur because of changes made as a result of therapy, emotional pain due to exploring personal issues and family history, emotional pain in current relationship, and possible increases in initial symptoms at the onset for treatment due to increased vulnerability and decreased effectiveness of previous defense mechanisms.
4. The ***therapy process and treatment planning*** begins with an initial treatment plan identifying goals for therapy for my child which is reviewed with me every 3 months or 6 sessions. The type of services my child will be receiving, duration and frequency will be identified on the treatment plan and reviewed with me.
5. My ***rights/my child's rights*** as a consumer of outpatient mental health and/or substance abuse services and my responsibilities in the development and implementation of your treatment plan. I understand confidentiality and the limits of confidentiality. More detailed information can be found on the Patient Rights & Responsibilities document.
6. The ***fees*** I am responsible to pay for the services. As a courtesy, Credence will submit my bill for services to my insurance company if I request and I am responsible for any deductibles and co-payments prior to each session. I am aware it is my responsibility to cover charges the insurance company does not cover.



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7. How to file a ***grievance*** if I am unsatisfied with decisions made by the therapist or the clinic. More detailed information can be found on the Patient Rights & Responsibilities document.
8. How I can obtain ***emergency mental health services*** including the emergency pager procedure and calling 911. More detailed information can be found on the Patient Rights & Responsibilities document.
9. The ***discharge policy***, including circumstances under which my child may be involuntary discharged such as outstanding balances on accounts, demonstrating behaviors that require a higher level of care and not attending scheduled sessions.
10. In the event the child's parents become involved in a ***custody dispute***, I understand that the child's records will not be released to either parent or their attorneys. If the therapist is subpoenaed to appear in court with or without the records, I understand that the attorney for Credence will make a motion to block the therapist or records from going to court. The policy at Credence is that it is not in the child's best interest for confidentiality to be broken in this manner.
11. I have a right to ***withdraw this consent*** by notifying my therapist. This consent to treat will expire 15 months from the date of the signature unless otherwise specified.

Additional information for those between the ages of 13 and (under the age of) 18:

12. If I am under the age of 18 years, I am aware that the law may provide my parents/guardians the right to examine my treatment records. If my parents request information about our work together, my therapist will ask them to accept a general outline of our work together instead of viewing my treatment records. ***Initial of Patient 13+ but less than 18 years of age*** \_\_\_\_\_
13. If there is a high risk that I will seriously harm myself or someone else, my therapist will notify my parents/guardians about their concerns. Before giving them any information about my therapy, they will attempt to discuss the matter with me, if possible, and do the best to handle any objections I may have with what they wish to discuss.  
***Initial of Patient 13+ but less than 18 years of age*** \_\_\_\_\_
14. I understand that my therapist is a "mandated reporter" which means that my therapist is required to break confidentiality if they believe that I am at risk of, or have a history of abuse or neglect which includes physical, sexual and/or emotional. The therapist is required to contact Walworth County authorities to make a report.  
***Initial of Patient 13+ but less than 18 years of age*** \_\_\_\_\_

*I have read and understand the information on this form and have had the opportunity to ask questions about this information and I acknowledge that it is my choice to participate in therapy. I realize that the outcome of therapy depends upon my personal investment in the therapy process. If I decide to terminate therapy, I will discuss termination with my therapist before ending treatment. If requested, have a received a copy of this document.*

Patient Signature (Age 13+): \_\_\_\_\_  
Signature Date

Parental/Guardian Signature  
(for clients under age 18): \_\_\_\_\_  
Signature Date

Witness Signature: \_\_\_\_\_  
Signature Date