Client ID: _____

ROCK COUNTY HUMAN SERVICES DEPARTMENT
Behavioral Health Division

INFORMED CONSENT FOR EVALUATION AND TREATMENT

1. **Consent to Evaluation/Treat:** I voluntarily consent to participate in a behavioral health evaluation and/or treatment by staff from a qualified behavioral health professional. I understand that following the evaluation, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment.
   b. Alternative treatment modes and services.
   c. The manner in which treatment will be administered.
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment.

   _____ **Comprehensive Community Services (specific):** If this is checked, your signature below verifies that you have been informed of the array of services offered by the Comprehensive Community Services Program (CCS). CCS is a consumer centered, recovery oriented psychosocial rehabilitation program for individuals of any age. Hours of operation are Monday through Friday 8:00 a.m. to 5:00 p.m. Your signature below indicates your consent to participate in CCS services and that you have received a copy of the CCS grievance procedure, consumer rights information, and other information stated in this consent.

   _____ **Community Support Program (specific):** If this is checked, your signature below verifies that you have been informed of the services offered and consent to the treatment provided by the Community Support Program (CSP). CSP is a consumer and recovery oriented program which assists individuals with managing and improving their mental health symptoms while teaching skills to help individuals meet their life goals. The hours of operation are Monday through Friday 7:30 a.m. to 4:30 p.m. When discharge from CSP occurs or is requested by the participant, the CSP team will make efforts to ensure that the participant is connected to follow up care and treatment.

2. **Benefits to Evaluation/Treatment**: Evaluation may include interviews, assessment forms, screening tools, and/or gathering information from other sources. The evaluation will include a diagnosis and a recommendation about further treatment, including the expected duration and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. In general, possible benefits to treatment include improved mood, behavior, relationships, daily functioning, and overall quality of life.

3. **Charges:** I understand that I am responsible for any payment for services that is not covered or reduced. I have completed the Financial Information Form (FIN002), and I have received and understand the Client Financial Policy form (FIN001).

4. **Confidentiality, Harm and Inquiry:** Information from my evaluation and/or treatment is contained in a combined paper and electronic confidential record. I have received and understand the Rock County Notice of Privacy Practices/HP002 and the Addendum to Notice of Privacy Practice for Human Services/HP003 which contain more information on how my medical information may be used and disclosed and how I can get access to this information.

5. **Emergency Services:** I may obtain emergency mental health services during periods outside the normal operating hours of the clinic by contacting Rock County Crisis Intervention at **608-757-5025**.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

7. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature. I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions or request a copy of my treatment records at any time.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____