***Family Services of Southern Wisconsin and Northern Illinois, Inc.***

***INDIVIDUAL AND FAMILY COUNSELING PROGRAM***

**Client Rights and Informed Consent**

Family Services wants you to be aware of your rights as a client of the agency and asks for your informed consent to receive services, including treatment. Included with this form is a pamphlet explaining your rights and the grievance procedure available to you. Please read the pamphlet carefully and keep it with your records. Questions regarding this document, any other document, or any other aspect of services may be directed to your counselor or other agency staff.

The following are general points of information about the counseling/therapy process and treatment.

* The **purpose of counseling/therapy** is to help alleviate (decrease) the problems and symptoms that you have identified.
* Counseling/therapy is conducted in sessions between you and an agency counselor/therapist and consists of talking about the problems presented.
* The counselor/therapist will discuss with you any **anticipated side effects** from counseling/therapy.
* Your counselor/therapist will suggest **alternative treatment modes or strategies** and assist in making referrals when appropriate and necessary.
* Your counselor/therapist will also talk with you about the possible **consequences of not pursuing counseling/therapy and the possible consequences of ending counseling/therapy prematurely**.
* The **content of all sessions will be held confidential** and can be disclosed outside this program only with your signed approval. EXCEPTIONS to confidentiality include (a) situations in which there may be a duty to warn others of risk of harm/injury, (b) situations requiring mandated reporting of suspected child abuse, and (c) audit of agency records by state licensure auditors and/or by accreditation agents. Records may also be subject to court and/or legal review.
* **Records of your involvement in services** shall be securely stored for a minimum of eight years following the end of services. Records of minors shall be kept for at minimum for a period of time that is concluded by the minor reaching the age of 26 (that is, eight years following the age of majority).

Your signature below indicates you are giving consent to participate in counseling/therapy sessions, that you understand your rights as a client of Family Services, including your right to the withdrawal of your consent to treatment and that an assessment of your treatment needs has been conducted, and that the treatment plan developed is appropriate. Your authorization for consent shall be otherwise valid for **maximum of 12 months** following the date of your signature. If you have any questions about your rights or any other treatment/service issue, please ask your counselor/therapist. We look forward to working with you.

It may be helpful for us to contact you regarding services and/or to verify appointments.

You may may not contact me at home. #\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

You may may not contact me at work. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to improve the quality of our services, we would like to provide you with a survey for your perspective and comments. Participation is optional:

I do I do not want to participate in client satisfaction surveys.

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 services/treatment.

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

\* Please print your name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_/\_\_\_\_/ \_\_\_

\* Please print your name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of clinician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_