Children's Service Society of Wisconsin™

A member of Children's Hospital and Health System.

Consent for Mental Health Evaluation and/or Treatment & Attestation of Legal Guardianship

Name:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I/my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Children's Service Society of Wisconsin. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes
   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. Possible consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me or my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my or my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Children's Service Society of Wisconsin, and I consent to disclosure for appropriate use by CSSW staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if you/your child are deemed to present a danger to self or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
5. **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.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.
7. **Discharge Policy:** The provider may discharge you from treatment for the following reasons: (a) you or your child completed treatment, (b) you or your child requests to end treatment, (c) you frequently miss appointments, (d) you do not contact the provider when missing repeated appointments, (e) you do not respond to (phone, letter or face to face) contact from the provider, (e) you are referred to another agency/provider for a different level or type of treatment, or (f) you are non-complaint with treatment recommendations.

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 am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of parent/legal guardian/patient if 18 or older **Date**

_____ _____

Signature of child age 14 years and older **Date**

_____ _____

Signature of witness **Date**