



A member of Children's Hospital and Health System.

INFORMED CONSENT POLICY (HSS 94.03)

It is the policy of this clinic that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive at this clinic. It is this clinic's policy to offer this information in both verbal and written form.

All patients will be provided, and should take, the necessary time to review this informed consent policy prior to the onset of their treatment. You may also ask for additional information from your therapist regarding any particular treatment.

Complete and accurate information must be provided concerning each of the following areas:

1. The benefits of the proposed treatment
2. The way the treatment will be administered
3. Expected side effects from the treatment and/or the risks of side effects from medication
4. Alternative treatment modes
5. The probable consequences of not receiving treatment
6. The time period for which the informed consent is effective
7. The patient's right to withdraw the informed consent at any time in writing

My signature indicates that I (1) have read and understand the policy and procedures pertaining to my granting of informed consent for the treatment which I choose to receive, and (2) have been presented with necessary and appropriate information either verbally or in writing and having had adequate time to consider this information, do hereby give my informed consent to participate in the recommended treatment. I have also received a copy of this document.

*I understand that this Informed Consent is good for one year following the signing date.
I understand that I can withdraw my consent, in writing, at any time.*

Date

Client

Date

Legal Guardian

Date

Witness

** Please talk to a therapist to understand the benefits and risks involved in treatment before signing and returning this form.**