INFORMED CONSENT

Consent to Evaluate/Treat: We realize that you have many options in choosing your healthcare providers and we appreciate you choosing Sherman Counseling in partnership with PACER Clinic, Delta Center, New Directions, and Baeten Counseling. I and/or members of my family will be receiving therapy, assessment and/or psychiatric services at Sherman Counseling Clinics beginning on this date. All policies, procedures and possible alternative methods of treatment have been explained to me by my therapist or provider. I have been informed of my client rights and authorize Sherman Counseling Clinics to provide mental health and/or services identified as appropriate I have been informed of the benefits of proposed treatment, the way treatment is to be administered, approximate length of treatment and any side effects which are a reasonable possibility, including risk of side effects from medication. I have also received information regarding alternative treatment methods and probable consequences of failure to receive treatment, as well as after-hours crisis coverage. This consent remains in effect throughout the duration of treatment (12 months maximum) and may be withdrawn by written request at any time. I am aware that my case will be periodically reviewed by Sherman Counseling Clinics, consulting psychologists, psychiatrists, and affiliated staff members.

Please check that you have been offered the following documents:

- ☐ Client Rights and the Grievance Procedure for Community Services, Grounds for Involuntary Termination, Notice of Privacy Practices and Telehealth Practices.

Technology Use: All records are stored on a secure cloud-based server and only your therapist has access to the information. Confidentiality of unencrypted communication such as email cannot be guaranteed. Please use the online secure email, if available for your location, to communicate with your therapist, set up a secure password, and use a secure network to log in. Use of public Wi-Fi is not a secure network. Sherman Counseling staff can use email or text to communicate with you about administrative details, such as appointment times and cancellations, but we cannot do therapy. Email is not secure or confidential.

Confidentiality, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record on HIPAA (Health Insurance Portability and Accountability) compliant web account and in a file at a Sherman Counseling Clinic, and I consent to disclosure for use by Sherman Counseling Clinics staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records. Confidentiality also applies to the waiting room. Should you see someone you know, please keep that information confidential.

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.

Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

Discharge Policy: There are three circumstances under which I may be involuntarily discharged which include unpaid balance or inability to pay for services. I understand the discharge policy of the clinic. If Sherman Counseling Clinics are not able to provide appropriate services, Sherman Counseling Clinics will refer me to alternative resources within the community and other agencies that can provide services. If I cancel without 24 hours' notice or no show my appointment more than 2 times my therapist has the right to discharge me and discontinue services.

Grievance Policy: If you feel that your rights have been violated or not respected, please speak to Dr Casey Hanson, Psychology@sherman-counseling.com. If you feel that your rights have not been respected or heard you have the right to contact the State Grievance Examiner, DHS (Department of Health Services), P.O. Box 7851, Madison WI 53707-7851.

*Baeten Counseling, Delta Center and New Directions are a division of Sherman Counseling.
Revised 8/24/2022*

<u>Consent to Treatment through Telehealth Services:</u> I consent to receive mental health treatment through telehealth services provided by Sherman Counseling Clinics. I hereby attest that the staff of Sherman Counseling Clinics have explained to me the policies, procedures, and alternative methods to this treatment. In addition, I agree to follow the policy and procedures of teletherapy/telemedicine services. I have been given documentation of these polices as well. I understand and agree with the following:

- I understand that I must be in the state of Wisconsin due to licensing restrictions.
- I understand there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that the provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.
- Confidentiality applies for telehealth services, and the session will not be recorded without written permission from both myself and the provider.
- I agree to use the videoconferencing platform selected for the telehealth sessions and the provider will explain how to use it.
- I understand that I will need to use a webcam or smartphone during the session and use a secure internet connection.
- <u>If I need to cancel or change my in-person or tele-appointment, I will notify the administrative staff in advance by phone. If I miss a scheduled appointment without notice, a no-show fee up to $150 will apply.</u>
- If a session ends due to technology failure in less than 20 minutes, and a reconnection is not successful, there will be no charge for the session.
- A safety plan will include at least one emergency contact and the closest emergency services to my location, in the event of a crisis situation.
- Permission of a parent/ legal guardian and contact information is required for minor clients in order to participate in telehealth sessions.
- I understand that I need to confirm that the telehealth sessions will be reimbursed by my insurance carrier; if they are not reimbursed, I am responsible for full payment.

I agree to work with my therapist on choosing the modality of the appointment whether that be in person, telehealth, or phone sessions.

___________________________________	____________________________________	______/______/______
Client Name (PLEASE PRINT)	Client Signature (14 years & older)	Today's Date
___________________________________	____________________________________	______/______/______
Parent Name (PLEASE PRINT)	Parent Signature	Today's Date
	____________________________________	______/______/______
	Clinician Signature	Today's Date

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