

**WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
CLINICAL DIVISION TREATMENT AGREEMENT**

Upon being admitted to treatment, I agree to the following:

I understand that:

1. My participation in outpatient treatment is voluntary.
 2. The outpatient clinic hours are Monday through Friday, 8:00 am to 4:30 pm. Evening hours are by appointment.
 3. I will be involved in my treatment planning.
 4. Staff will make discharge recommendations consistent with the evaluation of my needs.
 5. Staff will make appropriate referrals to other levels of care if such change is deemed necessary.
 6. Most health insurance policies and Medicare will cover treatment costs, or there are payment plans based on ability to pay.
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If I am participating in treatment for a substance use disorder, the following also apply:

- A. I will abstain from all mood-altering chemicals while involved in outpatient treatment.
 - B. Any absence from scheduled treatment hours must be approved in advance by my counselor.
 - C. The use of alcohol and/or other drugs, unauthorized absences, or other evidence of non-cooperation with treatment services, may be the cause for discharge or referral to an alternate treatment service.
 - D. The treatment process includes a series of: one-to-one interviews, group therapy sessions, requests for random observed urine screens and/or breathalyzer tests.
 - E. An appropriate family member or significant other may be expected to participate in a family conference.
 - F. I will not be required to participate in any segment of treatment, which is reasonably believed to be religious in nature. Refusal to participate in voluntary self-help groups will not be a basis for discharge from services.
 - G. If you are an I.V. drug user or involved sexually with someone who is using drugs intravenously (needles), you should be aware that you are at high risk for contracting the Human Immunodeficiency Virus (HIV). Please protect your health and learn the facts about AIDS. For more information, call (262) 896-8450.
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Waukesha County Human Services does an annual random follow up of discharged patients. You may receive a confidential follow up questionnaire after being discharged. Your cooperation in completing the questionnaire would be appreciated.

I HEREBY ACKNOWLEDGE THAT THIS FORM HAS BEEN EXPLAINED TO ME, AND I HAVE READ AND UNDERSTAND THE CONTENTS.

Name (Printed) _____

Patient/Guardian Signature _____ Date _____

Witness _____ Date _____