WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
OUTPATIENT CLINICAL SERVICES INFORMED CONSENT FOR TREATMENT

The Waukesha County Health and Human Services Department wants you to be aware of your rights as a patient of the Inpatient Hospital, Day Treatment Program, Community Support Program and/or Outpatient Clinic and asks for your informed consent to receive treatment. A copy is on display in the lobby.

(A) The benefits of being a recipient of services may include, but are not limited to, being better able to meet your personal needs, improved communication skills, clearer thought process, and more stable mood.

(B) Services provided may include psychiatric assessment, case management, group, individual, family and couples therapy. Upon the completion of psychiatric assessment, you have the right to learn of treatment recommendations. If medication is a part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.

(C) The risks of receiving services may include feelings of anxiety, depression, frustration, loneliness, helplessness or other intense emotions when you discuss life problems or experiences with your treatment providers. Certain medication may have common side effects that will be discussed with you at the time that you see the psychiatrist for a medication evaluation. It is your right, unless under court order, to decide whether or not you want to take any medication.

(D) As a consumer, you have a right and responsibility to participate in the development and implementation of your treatment plan. Duration of treatment and desired outcomes of treatment will be outlined in your treatment plan, which will be based on your needs and available services.

(E) If you disengage from services or elect not to participate, it is possible your problems may not be addressed or may become worse than they are at the present time.

(F) The treatment staff may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.

(G) Services never involve sexual contact between clinician and consumer. This is unethical and against the law.

(H) As a consumer receiving services from Waukesha County Department of Health and Human Services, it may be necessary for information about you to be exchanged with staff in different sections of the Human Services Department. The exchange of confidential information may be done without the notification of the patient (Wisconsin statue 46.23(10)). Such sharing of information among Human Services personnel shall be limited to that which is relevant to the particular services being considered, offered or delivered and will be done in a manner that considers the consumer's best interest and protects his/her right to privacy.

(I) This informed consent will be in effect until such time that you are discharged from services, or fifteen months from the date this consent is executed, whichever is sooner.

(J) You have a right to withdraw this informed consent, in writing, at any time.

(K) All consumers are expected to pay the fees associated with proposed services, as are determined by a meeting with a fiscal representative at the start of a treatment episode.

(L) The Waukesha County DHHS Policy on Involuntary Dismissal from Treatment is available upon request.

(M) During non-business hours, emergency mental health services can be accessed by contacting 211/Impact at 2-1-1 or (866) 211-3380 or (262) 547-3388.

DENIAL OF RIGHTS

Your rights may only be denied in certain circumstances such as:

1)
2) When there is a danger to life or health of the patient, or potential harm to others.
3) Suspected cases of child abuse or neglect. (s.48.98)
4) A lawful order of the court to which you must comply.

By my signature below, I attest that my rights as a consumer have been explained to me and I give my consent for treatment. I have also received a copy of the appropriate brochure "Client Rights and the Grievance Procedure for Inpatient or Residential Services" or "Client Rights and the Grievance Procedure for Community Services".

Consumer / Guardian* Signature**	Date & Time
Consumer's Name (PLEASE PRINT)	Date of Birth
Practitioner Conducting Discussion	Date & Time

** If consumer does not sign please document reason: _____

* If signed by a person other than the client, complete the following:

Client is: ☐ Minor ☐ Incompetent ☐ Unable to sign due to disability

Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Power of Attorney (POA)

☐ Other: _____

* If you check any of the above boxes, you must have proof of legal authority (i.e. Guardianship Papers, Power of Attorney documents) *