Phoenix Behavioral Health Services, LLC

3120 Memorial Drive Two Rivers, WI 54241 (920) 657-1780 FAX (920) 657-1784 www.phoenixbhc.com

Client Informed Consent & Acknowledgement of Program Policies and Procedures

This is to acknowledge that I have been provided with, both verbally and in writing, and understand the following information:

1. The general nature and purpose for outpatient treatment services and the services available through the clinic, including the benefits, administration and side effects of treatment.
2. Client responsibilities relating to treatment.
3. Alternatives to treatment modes.
4. Consequences of not receiving proposed treatment.
5. "Bill of Client Rights"
6. Clinic hours.
7. Treatment costs.
8. How to access emergency services.
9. Client rights and grievance procedure.
10. Criteria for discharge from treatment.
11. Follow-up services after termination of treatment.
12. 24 hours advance notice for cancellation of an appointment.
13. My rights to request consultation with consulting psychiatrist or psychologist.
14. Confidentiality of client information.

I consent to the treatment plan as described by my therapist until such time as I terminate treatment with Phoenix Behavioral Health Services, LLC or 15 months from the date signed. I understand that I may withdraw informed consent for treatment at any time by submitting such a request in writing to my therapist.

_____ _____

Client signature (or Legal Guardian) Date

_____ _____

Clinic Representative Signature Date

Please Note: *This consent automatically terminates 15 months after the date signed.*

Clients may request a copy of this consent form from their therapist if they wish to have one for their personal records.