INFORMED CONSENT FOR TREATMENT

MERCYLAND PSYCHIATRY
530 W. Main St., Sun Prairie, WI 53590

Last name: _____ First name: _____

Birthdate: _____ Email address: _____

In meeting with my provider, I have been given information on the following:

1. The results of the assessment including treatment recommendations and the manner in which the treatment will be administered.

2. The benefits of the treatment recommendations.

3. Possible outcomes and side effects of the treatment recommended.

4. Alternative treatments.

5. The probable consequences of not receiving the treatment recommended in the treatment plan.

6. The approximate duration and desired outcome of the treatment recommended in the treatment plan.

7. My rights in receiving outpatient mental health services, including my rights and responsibilities in the development and implementation of an individual treatment plan.

8. The fees that will be billed for the proposed services.

9. How to use the clinic's grievance procedure.

10. How to obtain emergency mental health services after our normal operating hours by calling 802-399-9114.

11. How an individual may be discharged from our services:

    a. If I display physical or verbal disruptive or threatening behaviors, criminal activity, or I pose a threat to another individual.
    b. If I represent myself in a fraudulent manner or provide misleading or inaccurate data.
    c. If I repeatedly schedule appointments and fail to maintain the appointment or obligations and responsibilities to attend and/or participate in treatment services.

Consent: I understand that in signing this document I am authorizing Mercyland Psychiatry to provide outpatient mental health and/or addiction services to me as discussed with the treatment provider. This consent shall be in effect for twelve months after the date signed. I understand that I can withdraw this consent at any time by submitting my request in writing.

_____ _____

Patient/Guardian Signature Date Time