Affiliated Wellness Group

Informed Consent for Treatment

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of the practice regarding confidentiality for your health information. Your rights as a patient are shown below. Privacy practices are shown in a separate document provided to you.

1. 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.
2. Services provided may include psychiatric assessment, case management, group, individual, family, and couples therapy. If medication is a part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.
3. 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 medications 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.
4. 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.
5. The treatment staff will discuss treatment recommendations, benefits of treatment, duration of treatment and outcome of treatment as well as associated fees with services.
6. The possible **benefits of EMDR** treatment include the following:
   • The memory may be remembered but the painful emotions and physical sensations and the disturbing images and thoughts may no longer present.
   • EMDR may help the mind reintegrate the memory and store it more adaptively. The client's own mind reintegrates the memory and does the healing

   The possible **risks of EMDR** treatment include the following:
   • Reprocessing a memory may bring up associated memories. This is normal and those memories will be contained so that they may be processed with a therapist at a later date.
   • During EMDR, the client may experience physical sensations and retrieve images, emotions and sounds or smells associated with the memory.
   • Reprocessing of the memory normally continues after the end of the formal therapy session. Other memories, flashbacks, feelings and sensations may occur. The client may have dreams associated with the memory. Frequently the brain is able to process these additional memories without help, but arrangements for assistance will be made in a timely manner if the client expresses difficulty coping.
7. The treatment plan may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.
8. You may be discharged from treatment for failure to follow through with treatment recommendations, failure to show up for appointments or abuse of medication.
9. Services never involve sexual contact between therapist and client; this is unethical and against the law.
10. This informed consent will be in effect no longer than fifteen months from the time that consent is given
11. You have a right to withdraw this informed consent, in writing, at any time.
12. Emergency after hours procedure will be reviewed by treatment staff.
13. Your therapist will not communicate with you via their private social media.

Denial of patient rights

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

1. When there is a danger to life or health of the client or potential harm to others.
2. Suspected cases of child or elder abuse or neglect. (s. 48.98)

3. A lawful order of the court to which you must comply.

By my signature below, I attest that my rights as a patient have been explained to me and I give my consent for treatment. I have also received a copy of the Rights and the Grievance Procedure, and a copy of the Notice of Privacy Practices.

_____ _____

Client/Guardian Signature* Date

_____ _____

Client's Name (Please Print) Date of Birth

_____ _____

Witness Date

* If client does not sign, please document reason:_____

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