CONNECTIONS COUNSELING LLC
together we recover

Patient Name:

Date:

Clients Rights Specialist, Inc.
Maria Hanson, JD
P.O. Box 14533
Madison, WI 53714-0533
(608) 446-8957

PLEASE READ BELOW AND SIGN. THANK YOU

Therapy cannot be defined in simple terms. I understand it varies depending on the personalities of the therapist and the particular issues I bring forward. I understand, in order for therapy to be most successful, it calls for a very active effort on my part. Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. I understand this creates safety to take risks and provides the support to become empowered to change.

I understand that all information shared with the therapists at Connections Counseling is confidential and no information will be released without my consent. In all other circumstances, consent to release information is given through written authorization. I further understand there are specific and limited exceptions to this confidentiality: when a specific statutory exception applies or a duty to warn exists. Connections Counseling is a certified outpatient drug/alcohol and mental health clinic. In my best interest, I understand that I may be required to participate in random urine drug screens. This may be further explored in individual sessions.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. However, the purpose of therapy is to alleviate problems and symptoms I present. I further understand it is the therapist's responsibility to suggest alternative treatment modes and will assist in referrals when appropriate and necessary.

I understand that I have the right to withdraw informed consent at any time in writing. Otherwise this consent will be valid for 15 months.

If I have any questions regarding this consent form or about the services offered at Connections Counseling, I may discuss such with my therapist. Also available if requested, is a pamphlet explaining your rights and the grievance procedure available to you. Please ask your therapist or the office if you would like a copy.

I have read the above information and have been notified of my rights and grievance procedure available to me. My therapist has also informed me of the cost of treatment. I hereby give my informed consent to receive treatment.

Patient Signature: **Date:**

Parent/Legal Guardian Signature:
(if patient less than 18 years old)

Staff Signature: