Evolve Counseling, LLC

Growth and insight through purpose -guided counseling

227500 Rib Mountain Drive Suite 101, Wausau, WI 54401

715-298-6201 www.evolvecounselingllc.com

INFORMED CONSENT (DHS 94.03/35.18)

1. **Consent to Evaluate/Treat:** I voluntarily consent that I/My child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or alternative treatments by staff from Evolve Counseling, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment services.
   b. Alternative treatment modes and services (for example: Brainspotting, EMDR)
   c. The manner in which treatment will be administered.
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment or services.

   The evaluation or treatment will be conducted by a, licensed professional counselor. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Social Work, Professional Counseling, or Marriage and Family Counseling credentialing board.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, and intake assessment. During the first two sessions therapist will discuss expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations, services and treatments may be offered. Uses of this evaluation may include diagnosis, evaluation of recovery or treatment, estimating prognosis, education, and mentoring. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I will be responsible for a ***$50.00*** cancellation/late fees if an appointment is cancelled without ***24*** business hour notice**.** **If my account reaches a balance of $200 that is not related to insurance collection, services can be suspended until the balance has been paid in full. If balance is not paid in full EC is informing you we use a collection agency.**
4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record on HIPAA compliant web account and in a file at Evolve Counseling, LLC, and I consent to disclosure for use by Evolve Counseling, LLC staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records. **Social Media** – EC has a policy of not "friending" current clients on social media. Due to the uncertainty of technology EC makes every effort to protect client's confidentiality. Please direct all queries to EC staff as social media is for informational purposes only.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.
7. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic. Evolve Counseling, LLC if not able to provide appropriate services, EC will provide alternative resources within the community.
8. **Grievance Policy:** If you feel that your rights have been violated or not respected please speak with Jan Spangler, LPC. If you feel that your rights have not been respected or heard you have the right to contact: State Grievance Examiner, DHS, and P.O. Box 7851, Madison, WI 53707-7851.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time. *If applicable:* I give permission for my child to receive evaluation and treatment by a therapist at Evolve Counseling, LLC. The types of services I am requesting from Evolve Counseling, LLC, have been explained to me. I voluntarily consent to become actively involved in the treatment process. I have read and understand the rights of a patient and informed consent.

Client Signature DATE:

Parent/Guardian Signature DATE:

Therapist Signature DATE: