NORTHSTAR DAY TREATMENT

6506 Schroeder Road
Madison, WI 53711
PHONE: (608) 270-1960
FAX: (608) 270-1965

Please read, sign and initial below:

NorthStar Day Treatment, in accordance with HSS rights statutes, wants you to be aware of your rights as a patient and asks for your informed consent to receive therapy.

A patient Bill of Rights appears in the waiting room. Please read this.

The following is some general information about the therapy process:

1. The benefits of mental health treatment are to help alleviate the problems and symptoms that you present.
2. We only do treatment and evaluations on a voluntary basis. You have the right not to participate in any treatment.
3. If medication is recommended, side effects will be discussed. Medication recommendations may be refused.
4. The therapist will suggest alternative treatment modalities and make referrals when appropriate or necessary.
5. The possible consequences of not receiving treatment will be discussed.
6. Informed consent is given for period of one year.
7. You have the right to withdraw informed consent at any time in writing.
8. Your therapist will develop a treatment plan which you will have the opportunity to modify, review and approve.

Please ask your psychotherapist if you have any specific questions.

I have received a copy of the “Client Rights and Grievance Procedure for Community Services” brochure and the “Notice of Privacy Practices” handout. ______ (initial here)

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Guardian Signature (for clients under 14) Date

______________________________ ______________
Witness Signature (if needed) Date