



Alternatives in Psychological Consultation  
10045 W. Lisbon Ave., Suite 221  
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## Consent for Treatment

Client Name: \_\_\_\_\_ ID#: \_\_\_\_\_

I, the undersigned, have been informed of the following on the date indicated below:

1. Type of treatment to be provided.
2. The way the treatment is to be given and services provided.
3. The expected treatment side effects or risk of side effects, which are possible.
4. Goals or benefits expected.
5. Who will provide the treatments and the therapist's credentials.
6. Estimated length of treatment.
7. Estimated cost of treatment and my ultimate responsibility for those costs.
8. Other available treatment
9. Probable consequences of not receiving treatment suggested.
10. Possible risks, if any, associated with treatment suggested.
11. If I disagree with any part or all of the treatment plan suggested, I can request a second opinion and will be assisted in obtaining that second opinion.
12. Procedures to follow in case of an emergency.
13. Name of my therapist's supervisor and that he/she is available at any time to me should I have a question, concern or complaint about my treatment.
14. My rights as a patient. I understand that information given within a therapeutic relationship shall remain confidential, excepting those circumstances outlined in Wisconsin Statutes which require a therapist to report the occurrence or likely occurrence of homicide, suicide, physical assault or child abuse.
15. Grievance procedures should I believe my rights were violated.
16. My consent to treatment does not include consent for participation in any research or educational programs in which this agency is involved or may become involved in during my treatment.

My signature below indicates my consent to the treatment plan described to me today. **I understand my consent automatically expires 12 months from the date in which my consent was given.** I do, however, have the right to withdraw this consent at any time I choose.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date