

# Consent to Treatment

I voluntarily choose to receive mental health services for myself and/or my child from Hoskinson Health and Wellness Clinic. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

## Nature of Mental Health Services

I understand that during the course of treatment I/or my child may need to discuss material of an upsetting nature in order to resolve concerns. I also understand it cannot be guaranteed that I/child will feel better after completion of treatment.

## Compliance with Treatment Plans

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow any treatment plan in any form.

## Supervision

I understand there are certain circumstances which may require Hoskinson Health and Wellness Clinic provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision.
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed.
3. The standards of care which guide most mental professionals recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others.
4. Accountants or agencies that require audits of financial records.
5. Other special circumstances, such as preparation to testify in court.

## Client Rights

- The right to be treated with dignity and respect by all staff.
- The right to be involved in the planning and/or revision of my treatment plan.
- The right to know about my treatment progress or lack thereof.
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used.
- The right to be spoken to in a language that is fully understood.
- The right to a clean and safe environment.
- The right to refuse to be videotaped, audios recorded, or photographed.
- The right to end treatment at any time unless court ordered.
- The right to file a complaint or grievance about the agency or staff.
- The right to confidentiality of clinical records and personal information according to federal and state laws.

## Hours and Emergencies

Hoskinson Health and Wellness Clinic's hours are Monday through Friday from 8:00 am to 5:00 pm. We are closed on weekends and holidays. No after hour services are available. Hoskinson Health and Wellness Clinic is not a Chronic Care or Crisis Facility. I understand I may reach my provider at (307) 387-9850. If not available, I can leave a message and my call will be returned as soon as possible during normal business hours.

If I have a life threatening emergency, I should call 911 or go to the emergency room.

## Minors

**Responsible party please be aware that the parent or guardian who signs this consent form is legally responsible for payment regardless of whether or not they are the insurance holder.** In the event of separation or divorce, the parent or guardian who signs this form is legally responsible for payment. We cannot send statements to other parties. Reimbursement must be made between divorced parents. We will not intervene.

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to, and authorizes services by Hoskinson Health and Wellness Clinic providers.

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Signature of Patient or Parent/Legal Guardian