

Genesis Counseling Services, Ltd.

One South Main St. * P.O. Box 8010 * Janesville, WI 53547-8010 * 608-757-0404 * Fax 608-757-2319
www.genescounselingservices.com

Client Rights and Informed Consent

Genesis Counseling Services is certified by the Wisconsin Department of Health and Family Services to provide Out-Patient Mental Health and Substance Abuse treatment. Clinic standards have been developed to ensure that services of adequate quality are provided to clients. Providers are under the supervision of a licensed psychologist or psychiatrist.

The purpose of mental health therapy and/or substance abuse therapy is to alleviate problems and symptoms that the client presents for focus. Client and therapist develop a treatment plan, which includes short-term and long-term goals. Therapy is conducted in 50-minute sessions.

During the first session, the therapist will review:

- The services, treatment alternatives and recommendations;
- Possible outcomes, including benefits and side effects;
- Approximate duration and desired outcome;
- The means by which a consumer may obtain emergency mental health services;
- The clinic’s discharge policy, including circumstances that may result in involuntary discharge.

Confidentiality:

Unless a specific exception exists, your provider will not speak or otherwise share information with anyone, outside of a parent or legal representative, without signed written consent. If a client reveals that they intend to seriously injure themselves or someone else, or if there is reasonable probability of such harm, the provider has a legal responsibility to alert the client’s family and/or the appropriate law enforcement agency.

The law specifically requires providers to report any knowledge of child abuse. If a client is being investigated for child abuse, child neglect, sexual molestation or other such offenses, this clinic may be lawfully contacted for information bearing upon these charges and required to cooperate with this request for information.

Client Rights and Privacy Practices:

You have received a copy of the **Client Rights and Privacy Practices**. If you have any questions regarding that information, please feel free to discuss such with your provider. If you believe that your client rights have been violated, you may contact the Client Rights Specialist whose address and phone number appear on that form. If you believe that your privacy rights have been violated, you may ask to speak with the Clinic Administrator, or submit a written complaint to the U.S. Department of Health and Human Services.

With my signature below, I acknowledge that I have read (or had read to me) the above information. I have reviewed the client rights, privacy rights, and grievance procedures. I understand this information, and I give my consent to treatment with the understanding that I may withdraw my consent at any time in writing.

Client/Representative Signature / Date

Office Staff Signature / Date