WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Acknowledgment of Informed Consent, Rights & Responsibilities, Privacy Policies and Advance Directive Options- Version 13R

Informed Consent **Initial**

I have read and understand the risks & benefits related to treatment and evaluation at Western Psychological & Counseling Services (Western). I consent to receive mental health services by Western. Any questions I have regarding these have been answered. _____

Rights & Responsibilities **Initial**

I have reviewed and understand my rights and responsibilities for receiving services at Western. This includes complaints, fees, no-show/cancellation policies, and my rights. I have a copy of these rights and responsibilities. Any questions on these have been answered. _____

Notice of Privacy Practices **Initial**

I have reviewed Western's privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have a copy of these policies. I understand that Western will share basic information with primary care provider unless I ask to "restrict" this disclosure. _____

Financial **Initial**

If I cancel within 24 hours or do not show for an appointment, I will pay $55 (OHP and General Fund excepted). I am the "financial guarantor", meaning I will be responsible for payment of co-pays, co-insurance, deductibles, and fees for services not covered by a plan or EAP. _____

Advance Directive	**Yes**	**No**
I would like more information about how to make a medical advance directive.	☐	☐
I would like more information about how to make a mental health advance directive (called a "Declaration for Mental Health Treatment")- Oregon only.	☐	☐

Print Client Name:_____ Client Date of Birth: _____

If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other_____

Signature of Client or Parent/Guardian: _____ Date:_____