CORNERSTONE CLINIC
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Informed Consent and Clinical Policies (Full Text)

This document explains the rights and responsibilities within the therapeutic relationship (i.e. the patient and clinic employee). It is important to be aware of the following as it helps to create the safety to take risks and the support to become empowered to change. This constitutes your informed consent regarding treatment and our administrative policies.

Section One: Informed Consent

1. I hereby request and consent to outpatient treatment by Cornerstone Clinic, LLC.
2. During my involvement in outpatient treatment at Cornerstone Clinic, I will receive an evaluation in which my presenting problems will be addressed, and I will learn ways to help alleviate them. I understand that the clinical staff will outline recommendations which they will conclude are medically necessary and/or potentially beneficial to my mental health.
3. In the event that I am prescribed medications as part of my outpatient treatment, I will be informed of any possible side effects or risks.
4. If a referral to inpatient care becomes necessary, Cornerstone Clinic will make attempts to reasonably coordinate that level of care, but it is ultimately my responsibility to obtain inpatient care and treatment.
5. I understand that other treatment facilities of similar nature are available in central Wisconsin offering both inpatient and outpatient treatment, and that I can be referred or can seek a second opinion from an outside referral source if necessary.
6. I hereby acknowledge that I am voluntarily seeking outpatient mental health treatment, and I understand that certain mental illnesses left untreated may be harmful to one's physical, social, vocational, legal and psychological health.
7. This informed consent will be valid until such time that my treatment provider or I terminate treatment up to a maximum of one year. I have the right to withdraw this informed consent at any time during treatment if the request is made in writing. If I am a minor 14 years of age or older, I understand that I have the right to refuse to sign the informed consent.
8. I have been given adequate time to study and ask questions prior to signing the informed consent.

Patient Signature (adult or 14 years or older) _____

Date _____

Parent Signature (patient is minor) _____

Date _____

Section Two: Confidentiality

With the exception of certain specific exceptions described below, everything you talk about in therapy, as well as the fact that you're attending therapy, will be kept confidential. Under the provisions of the Health Care Information Act of 1992, your written consent is required for us to talk to anyone about your treatment, unless in an emergency. You may choose to issue and/or revoke your consent at any time.

The exceptions to confidentiality include:

- When there is risk of imminent danger to you or another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child and to inform the proper authorities.
- When a valid court order by subpoena is issued for medical records, the clinician and Cornerstone Clinic are bound by law to comply with such requests.

Cornerstone Clinic does not provide clinical information or release records to government agencies (unless absolutely required by law or court order), current or future employers or others, even with your permission. We highly recommend that you talk with your therapist about the potential consequences of releasing your own records for purposes other than continuity of care by other healthcare professionals. We will, at your request, provide clinical information to another health professional for the purposes of your further treatment.

Our primary responsibility is to ensure safety whenever possible. As therapists, we are required by law to report any of these threats or behaviors in order to ensure that safety. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law requires the confidentiality of all electronic transmission of information about you for the purposes of treatment and referral, billing and collection, and operational purposes. Whenever we transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to ensure confidentiality.

Please also keep in mind that this confidentiality extends to accidental run-ins with clinic staff in the community. Our staff live and shop in this community just like you do and if they see you, they will not acknowledge you first. This is to protect your confidentiality, not because our employees are ignoring you. Should you decide to break confidentiality and say hello, they will acknowledge you in return. However, no clinical conversations should be taking place outside of the clinic building. Please save conversations of a therapeutic nature for the office, for your sake and ours.

Special Notes Regarding Confidentiality

Minors and Therapy

A parent who consents on a minor's behalf has the right to know the content of the child's treatment. That consent changes when the minor reaches the age of 18. Until that time, the law will normally give the parent access to the child's treatment. However, an important aspect of treatment is to foster the child's autonomy/independence. Our employees kindly request that the sessions are confidential in order to foster the client/therapist relationship, develop trust, and to expedite the therapeutic process. Such decisions to breach confidentiality are listed above; however, when deemed in the best interest of the client, the client and therapist will work together to discuss with the parent any pertinent information that the parent should know. A person who is 14 years or older must agree with his/her parent to receiving outpatient mental health services.

Couples and Therapy

You and/or your partner may decide to engage in individual sessions as part of the couple's therapy. What each individual partner says in those individual sessions will be considered part of the couple's therapy and can, and probably will, be discussed in joint sessions. Do not disclose to the therapist anything you wish to keep secret from your partner. If you would like individual sessions with another therapist to protect your privacy, please let us know, and we will make an appropriate referral within the clinic.

Section Three: Appointment Policy

Please arrive 10 minutes early for your appointments. Missed appointments reduce our capacity to provide services to you and other clients. If you are unable to keep your appointment, please call to cancel as far in advance as possible.

If you no-show or cancel appointments with less than 24 hours' notice two times or more:

1. You may be offered time slots that are shorter and at the end of the clinician's work day.
2. You may be involuntarily discharged due to non-compliance with treatment.

In the event of a cancellation or no-show, you are responsible for confirming or scheduling your next appointment.

Section Four: Expectations of Patient and Clinical Staff Interactions

The clinical staff will work together to provide the best possible care for you in a respectful environment. Your commitment to us in return is that your behavior will also be respectful and appropriate at all times.

1. I will engage in respectful interaction with the providers, therapists and staff, whether on the phone or in the clinic.
2. I understand that the following behaviors will not be tolerated and are cause for my immediate dismissal from the clinic/appointment:
    a. Profane or disrespectful language
    b. Yelling, berating, throwing objects, slamming doors, or insulting others
    c. Bullying, demeaning, or intimidating conversations
    d. Sexual comments or innuendo
    e. Insidious intimidation, such as sarcasm, nonverbal gestures, or passive–aggressive behavior
    f. Refusal to cooperate with the provider or staff (for example, refusal to answer questions, refusal to submit urine for urine drug testing, etc.)
    g. Unaddressed hygiene concerns that affect other patients and/or clinical staff
    h. Any recording of any sessions or treatment whether in-person or telehealth without consent of everyone involved
3. I understand that if such behavior occurs, it will ultimately be the decision of the clinical director if I will be discharged from the clinic.
4. I understand that any physically threatening behavior demonstrated by me will result in the immediate termination of my care.
5. I understand that Cornerstone Clinic has zero tolerance for any alcohol or drug use on the premises, abusive actions or language, or any other behavior that creates risk or threat to patients, families, visitors, or care team. Anyone, including family members, violating this policy will be asked to leave the premises. If necessary, clinical staff will contact the police.
6. I understand the importance of keeping and being on time to all scheduled appointments.
7. I agree to adhere to the payment policy outlined by Cornerstone Clinic.
8. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of medication is a serious violation of this agreement and would result in treatment being terminated.

9. I agree to follow my treatment plan as discussed with the provider and care team or respectfully disagree and discuss alternatives.
10. I understand that if medication is recommended, meeting with a mental health therapist is also mandatory and the frequency for which that counseling occurs is ultimately up to clinical staff.
11. I understand that violations of the above points may be grounds for termination of my treatment.

Patient Signature
(adult or 14 years or older) _____

Date _____

Parent Signature
(patient is minor) _____

Date _____