SOUTHWEST IOWA MENTAL HEALTH CENTER

Acknowledgement Statement

☐ I acknowledge that I have received a copy of the Notice of Privacy Practices.

☐ I acknowledge that I have received a copy of the form: Overview of Client's Rights, Responsibilities, and Procedures and that I have read and understand the form.

☐ I acknowledge that I have reviewed and completed the form: Charges for Services.

☐ I acknowledge that I have reviewed and completed the form: Authorization to Disclose Information to Primary Care Provider.

By signing below, you are indicating that you have been provided with appropriate and adequate information to permit you to make an informed decision regarding participation in treatment. Your signature also verifies that you were provided the opportunity to ask questions about treatment and that you were given adequate answers to the questions asked.

Additionally, by signing below I am acknowledging that I have been provided with the following information:

- Description of the treatment and interventions that will be used in the course of treatment as they relate to your diagnosis.
- Advisement that I have the right to decline or refuse to participate in prescribed procedures, techniques and treatment.
- Right to refuse or withdraw from treatment at any time, for any reason.
- Explanation of the intended outcome and the anticipated benefits of treatment with understanding that there is no guarantee that treatment will result in the desire outcome. In fact, some individuals' conditions worsen during the course of therapy.
- Information about alternative, less restrictive, and/or less intrusive treatment options.
- Grievance/compliant process

_____ _____

Patient signature Date

_____ _____

Signature of Parent, Guardian, or Legal Representation Date

_____ _____

Signature of Clinician or Physician Date