Associates for Psychiatric Services, P.C.

600 4th Street

Suite 501

Sioux City, IA 51101

712-234-0220

Fax 712-234-0225

www.afpssc.com

Client Rights and Informed Consent – Guideline

- I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by the court.
- I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the **Basic Rights of Individuals** including:
  - The right to be informed of the various steps and activities involved in receiving services.
  - The right to share in the formation of the plan of care/treatment plan.
  - The right to confidentiality under federal and state laws relating to the receipt of services.
  - The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
  - The right to make an informed decision whether to accept or refuse treatment.
  - The right to contact and consult with counsel at my expense.
  - The right to select practitioners of my choice at my expense.

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

____________________________________ ______________________

Signature of Patient/Client Date

____________________________________ ______________________

Signature of Parent/Guardian/Conservator or Authorized Representative, if required Date

Philip J. Muller, D.O.

Ejiro V. Agboro-Idahosa, M.D.

Daniel W. Gillette, M.D.

Glenda DenHerder, A.R.N.P.

Jeannie L. Franklin, A.R.N.P.

Keith A. Karstens, D.Min., Psy.D.

Clayton J. Toddy, Psy.D.

Beth E. Harms, LISW

Susan B. Richards, LISW

Patricia R. Wahlen, LISW