Patient name			
MHN	DOB	Age	Gender

Client's Bill of Rights/Grievance Process/Treatment Costs

Psychiatric/MH Treatment Consent/Acknowledgement

Informed Consent to Treatment

I have received, read and understood the information on informed consent for treatment contained in the brochure entitled *Informed Treatment Consent & Rights*. I understand that I have the right to discuss the following topics with my mental health provider: the benefits of the proposed treatment and services, the way the treatment is to be administered and the services are to be provided, the expected treatment side effects or risks of side effects (including side effects or risks of side effects from medications), alternative treatment modalities and services, option of using telehealth, and the probable consequences of not receiving the proposed treatment and services. This consent to treatment is effective for 15 months from the date of my signature. I understand that I may withdraw this consent at any time except to the extent that my providers have taken action in reliance upon this consent. I understand that if I refuse to give this consent to treatment I cannot be treated.

_____ _____/_____/_____ _____
Patient's signature Date (month/day/year) Time

☐ Patient's legal representative signature is not required.

_____ _____ _____/_____/_____ _____
Patient's legal representative signature Relationship Date (month/day/year) Time

(Patient initial appropriate response: _____ Accept _____ Refuse)

Acknowledgement of Client's Bill of Rights/Grievance Process/Treatment Costs

I have received, read and understand the information contained in the brochure entitled *Informed Treatment Consent & Rights* on the following matters pertaining to my care and treatment:

- The client's Bill of Rights
- The grievance process and availability of client rights specialists
- The cost of care and treatment

_____ _____/_____/_____ _____
Patient's signature Date (month/day/year) Time

☐ Patient's legal representative signature is not required.

_____ _____ _____/_____/_____ _____
Patient's legal representative signature Relationship Date (month/day/year) Time

