Patient name			
MHN	DOB	Age	Gender

Telehealth

Psychiatric/MH Treatment Consent

I have received, read and understand the information on informed consent for treatment contained in the brochure entitled *Your Rights As a Patient of the Marshfield Clinic Health System Department of Psychiatry and Behavioral Health.*

- I understand that the services I will receive will be provided via telehealth and that there is an increased risk for loss of security/privacy when using technology. I also acknowledge my right to receive services from a provider who can see me in person.
- 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; the probable consequences of not receiving the proposed treatment and services. This consent to treatment is effective for 12 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 actions in reliance upon this consent.
- I understand that if I refuse to give this consent to treatment, I cannot be treated.

By my signature, I acknowledge that I have received an explanation and understand the information as stated above.

Patient signature ______ PRINT patient name ______ Signature date (m/d/y) ____/____/____ Time ______

Authorized person to consent for patient signature ______ Relationship to patient ______ PRINT authorized person name ______ Signature date (m/d/y) ____/____/____ Time ______

Witness signature ______ PRINT witness name ______ Signature date (m/d/y) ____/____/____ Time ______

I have personally explained the above information to the patient or the patient's representative.

Provider signature/title ______ PRINT provider name ______ Signature date (m/d/y) ____/____/____ Time ______

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

I have received, read and understand the information contained in the brochure entitled *Your Rights As a Patient of the Marshfield Clinic Health System Department of Psychiatry and Behavioral Health* 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 ______

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