Outpatient Consent and Acknowledgement

I hereby acknowledge that I have received and have been given an opportunity to read a copy of CCW's statement of consumer rights, limits of confidentiality, no show/cancellation policy, privacy policy, and grievance process. I understand the benefits of receiving treatment and probable consequences of not receiving treatment, and consent to discussing treatment and to being treated. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact CCW, Attention Privacy Officer at 715-845-5493.

I understand this consent can be withdrawn from me at any time, and that I am entitled to a copy of this consent at any time.

I, _____, parent/guardian of _____
(Print Name) (Print Child Name)
acknowledge that by signing my name below that I have been informed and understand the consumer rights, limits of confidentiality, no show/cancellation policy, cost of treatment, privacy policy, and grievance process.

I additionally consent to communications via (*initial next to communication type*)

_____ Phone calls (Preferred Phone Number) _____

(Alternate Phone Number) _____

_____ Permission to leave message at Preferred Number □ Yes □ No
_____ Permission to leave messages at Alternate Number □ Yes □ No

_____ Ability to respond to e-mail communication ***initiated by you*** (It is not our practice to send e-mails or put you on a list serve. However, if you e-mail us, we require your permission for us to respond.) ****Emails are NOT encrypted.**

_____(e-mail address required, if yes)

_____
Signature of Consumer Date

_____
Signature of Guardian Date

_____
Signature of Witness Date

This consent is valid for 15 months from the date of the signature.