**If client is a child or has a legal guardian these must be signed by the legal guardian**

1123 1st Ave E Suite 200 Newton IA 50208 Phone # 641.792.4012 Fax # 641.791.0697
200 4th Ave W Grinnell IA 50112 Phone # 641.260.8270 Fax # 641.260.8213

**Receipt of Client Information**
**And Consent for treatment**

Client's Name ______________________________________ DOB ____________________

## Receipt of Client Information

I have received the Capstone information packet. This packet contained a copy of the office hours, the goals of the program, rules governing conduct, client rights and responsibilities, financial agreement, standard fees and charges for services, confidentiality and neglect and abuse policy.

I understand I can review the Appeal/Grievance procedure in the client handbook and I can review my rights as a client outlined in the handbook.

I have received a copy of Capstone's Notice of Privacy Practices outlined in the client handbook and the HIPPA privacy statement was made available at the front desk.

I understand the results of the assessment will be discussed with me when I meet with my counselor.

My demographic information has been reviewed with me by the office staff. To my knowledge all of my information is current and correct.

## Follow-Up Agreement

I agree to be contacted by phone or mail for purposes of quality improvement following discharge from Capstone Behavioral Healthcare. ☐ Yes ☐ No __________ **(Initials)**

## Consent for Treatment Services

I consent to treatment services at Capstone Behavioral Healthcare for myself or for the person for whom I am the parent/legally authorized representative. I understand that Capstone services are provided by a variety of mental health and substance abuse professionals. (Capstone services may also be provided by a "professional in training." All professionals in training are supervised by a licensed or certified professional.) I understand that while mental health or substance abuse treatment may provide significant benefits, it also poses some risk. Psychotherapy and counseling may cause thought, feeling, or memories to surface which may be uncomfortable or even painful. Medication prescribed by a physician or nurse practitioner may have side-effects. I acknowledge that no guarantee has been made to me concerning the effect of treatment. My signature below indicates that I have reviewed and understand the Consent for Treatment Services and that I consent to treatment.

______________________________________ ____________________________

Client Signature/Legal Guardian Date

Witnesses by ______________________________________