

Christie Tanner, PsyD, LLC

4606 Commerce Valley Road, Suite 211
Eau Claire, WI 54701
Ph. (715) 833-1611; Fax (715) 833-2121

Informed Consent for Treatment

Informed consent means I understand the following information:

A. The types of treatment services provided by Christie Tanner, PsyD, LP include individual, couple and family sessions, as well as group therapy. Treatment goals will be defined on an individual basis according to my needs.

B. The potential benefit of treatment services is progress toward my goals and objectives. This may include improved self-esteem, increased self-understanding, improved management of mood or behaviors, etc. as defined by my treatment plan.

C. Side effects or risks in treatment may include progress being slow, changes in relationships, various feelings may surface (sadness, anger, depression, etc.), and things may get worse before they get better.

D. Limits on confidentiality: Discussions with my therapist are confidential in most circumstances. The most likely exceptions are as follows: 1) I am an abuser of a child; 2) I make direct, serious threat to harm myself or another person; 3) I am involved in a personal injury lawsuit in which I have placed my mental condition as an issue; or 4) a judge orders that confidentiality be lifted in any kind of a case through a court order or subpoena of records.

E. Alternatives to psychotherapy may include the options of continuing to resolve matters on my own; talking to a friend; reading information about symptoms; taking a class; or trying exercise. If at any time I do not feel my therapist is meeting my needs, he/she would be happy to recommend other therapists.

F. Consequences of not receiving the proposed treatment services may be that the symptoms stay the same or get worse; relationships may suffer; the symptoms may interfere with daily activities such as sleep, relationships, or job performance, etc.

I hereby acknowledge that I understand the above information and give consent for the administration of treatment services by Christie Tanner, PsyD, LP. I have reviewed the above information and understand that I can ask questions at any time. I have also read and understand my patient rights and have received a grievance procedure information sheet. I have received a copy of the Outpatient Services Contract and agree to abide by its terms. I have also received a copy of the Notice of Privacy Practices and understand that I can review this information at any time with my therapist. In accordance with this consent, I authorize Christie Tanner, PsyD, LP to release to my designated health insurance provider, all information necessary to secure payment of my medical benefits. I understand that I can revoke this authorization at any time but that I must do so in writing. I further understand that, if not revoked, this authorization expires one year from the date I sign it. This consent is in effect for 12 months from the date of signature and may be withdrawn at any time.

Please check one:

- I authorize Christie Tanner, PsyD, LP to exchange information about my treatment and/or current health status and history with my primary care physician for the purpose of coordinating services and ensuring continuity of care. Please request a Release of Information Form at your first appointment.
- I do not have a primary care physician.
- I have a primary care physician but do not wish to authorize an exchange of information at this time.

Signature	Please Print	Date
Parent/Legal Guardian Signature	Please Print	Date
Witnessed By Signature	Please Print	Date