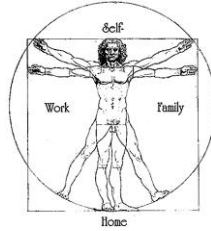


4785 Hayes Road
Madison, WI 53704
608-242-7160
Fax 608-242-7153



COUNSELING RESOURCES NEUROPSYCHOLOGICAL ASSOCIATES, LLC Informed Consent to Treatment

Patient: _____ DOB: _____

I have been provided information regarding the following treatment:

- Interviews
- Psychotherapy
- Neurobehavioral/Neuropsychological/Psychological Evaluation (Testing)
- Cognitive Training
- Telehealth Service: Therapy Interviews Evaluation Results
- Other _____

I understand I have the right to information concerning the following:

- 1) the benefits and purpose of treatment;
- 2) the manner in which the treatment is to be administered;
- 3) alternative treatment modes;
- 4) the probable consequences of not receiving proper treatment.

Treatment is being provided:

- at the patient's request
- at the request of (name & relationship) _____

Treatment is to be provided at:

- Counseling Resources Neuropsychological Associates
- Dodge County Human Services, 199 Home Rd., Juneau, WI 53039
- Other _____

My informed consent will remain in effect for 12 months from the date this consent is signed or until case closure. I understand that I may withdraw my informed consent at any time in writing. My signature on this form indicates my consent to the above treatment. A copy of this document is considered to be as valid as the original.

Patient Signature (if age 14 or above*): _____ **Date** _____

If patient lacks sole legal authority to sign for him/herself (e.g., if patient is under age 18, or over 18 and legal guardianship is in place) complete the following:

Patient is unable to sign because: _____

Authority of Personal Representative: Parent ____ Health Care POA ____ Guardian ____ Other ____

Personal Representative Name and Address: _____

Personal Representative Signature: _____ **Date** _____

(*Note: If patient is age 14 to 17 years, both the personal representative and adolescent signatures are required for authorization.)