WEST YAVAPAI GUIDANCE CLINIC
CONDITIONS OF ADMISSION AND INFORMED CONSENT FOR TREATMENT

1. **AUTHORIZATION FOR VOLUNTARY TREATMENT**: I, _____
PRINT CLIENT NAME

Authorize and agree for West Yavapai Guidance Clinic to administer such treatment as is necessary while I am receiving services. WYGC will explain in detail a specific treatment or a change in treatment, such as the use of a different medication. I understand I will be offered verbal information and explanation of services being proposed, the intended outcome from my participation in the services, the nature and procedures of the proposed treatment, and the risks and side effects of the proposed treatment. I also understand I will be offered verbal information regarding the risks of not proceeding with the proposed treatment and be informed of alternatives to the proposed treatment. I understand informed consent is voluntary and I may withdraw or modify my consent to treatment at any time in writing. I understand my care is under the direction of the Medical Director and may be carried out by the doctor, nurses, therapists and other staff employed by West Yavapai Guidance Clinic.

2. **RELEASE OF INFORMATION**: Specific authorization is required for release of information. Please see WYGC Privacy Notice.

3. **PERSONAL VALUABLES**: I agree that West Yavapai Guidance Clinic will not be held liable for the loss or damage to any money or personal valuables that I bring with me while receiving outpatient services. Inpatient services maintain a safe for the safekeeping of money and valuables of inpatients. I agree that West Yavapai Guidance Clinic is not liable for the loss or damage to any money or personal valuables unless deposited in the agency safe. West Yavapai Guidance Clinic shall be liable for no more than $250 per patient for the loss or damage to items of personal property deposited in the agency safe.

4. **FINANCIAL AGREEMENT**: I understand that I will be required to make financial arrangements with the finance department. I understand that I may be responsible for any co-payment for services rendered.

5. **PROGRAM RULES**: I agree to abide by the program rules established by West Yavapai Guidance Clinic as these are explained to me during the orientation procedure.

6. **PARENTAL CONSENT:** Your personal concerns about the services, the current well-being of your child, or the fees are welcomed at any time, and we expect you to take responsibility to communicate such concerns to the West Yavapai Guidance Clinic Staff.

The West Yavapai Guidance Clinic Staff will make every effort to ensure the safety of your child and others. If your child presents an imminent danger of hurting themselves, another person or seriously damaging property, the staff will use a Therapeutic Hold to prevent harm. WYGC staff is trained in therapeutic holds and will use non-physical de-escalation techniques whenever possible. Your signature releases the staff and clinic from any liability resulting from the use of therapeutic hold. As parents/guardians, you may withdraw your child from services at any time, except in life-threatening situations.

I HAVE READ THE ABOVE AND UNDERSTAND THE CONTENTS OF THIS FORM AND HEREBY AGREE AND CONSENT TO TREATMENT AT WEST YAVAPAI GUIDANCE CLINIC.

_____ _____
Client Signature Date

_____ _____
Legally Authorized Representative/Guardian (PRINT NAME) Rep/Guardian Signature

_____
Relationship to Client