Advanced Women's Healthcare

INFORMED CONSENT FOR TREATMENT

1. I understand that Advanced Women's Healthcare complies with those standards set forth by HIPAA. No information will be shared without my written consent. However, there are exceptions such as suspected abuse and if my therapist strongly believes I am a danger to myself or others. While these situations are rare, we will take action such as notifying the police, notifying the potential victim(s), seeking hospitalization for you, contacting family members, or others who can provide protection. All therapists are mandated reporters and must report any form of abuse to DCFS (including child and elderly abuse). We are also obligated to report if you are determined to be a "clear and present danger" to yourself or others, or have an intellectual or developmental disability to the FOID reporting system. (_____)
2. You understand that Advanced Women's Healthcare cannot be held responsible for providing services in the event of a crisis or emergency situation that arises outside of session. If you believe you are a harm to yourself or others immediately contact 911 or go to your local emergency room or contact Suicide Prevention Services at 800-273-8255. (_____)
3. You agree not to attend sessions while under the influence of alcohol or other drugs. If the therapist believes the client is under the influence of alcohol or drugs, the session may be canceled. (_____)
4. You agree not to bring any weapons or any objects that may act as a weapon to their session. (_____)

Please list all previous psychiatric hospitalizations, if any, in chronological order (most recent first):

Name of Hospital	Date (from-to)	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had thoughts, plans or actions related to self-injury? Yes ___ No ___

Have you ever had thoughts, plans or actions related to suicide? Yes ___ No ___

If answered yes,

When was the most recent? _____

Do you have a current plan for suicide or self-injury? _____

Do you have hopes for the future? _____

_____ _____

Patient's Signature Date