

**WESTSIDE INFANT – FAMILY NETWORK (WIN)**

**CONSENT FOR MENTAL HEALTH TREATMENT AND CASE MANAGEMENT & ACKNOWLEDGMENT OF POLICIES**

**CONSENT FOR TREATMENT**

(initial) \_\_\_\_\_

By signing this form, I authorize the WIN therapists to provide mental health evaluation and treatment services to: \_\_\_\_\_. I understand that I have the right to (1) receive a copy of this consent and (2) withdraw this consent at any time by submitting a written withdrawal notice.

**CONSENT FOR CASE MANAGEMENT**

(initial) \_\_\_\_\_

I understand that WIN is a multi-disciplinary agency, and is affiliated with St. Joseph Center, Venice Family Clinic, Westside Children’s Center, Mar Vista Family Health Center, Westside Family Health Center and the St. John’s Infant & Family Support (the “Network Providers”). I have been informed that my WIN therapist may occasionally need to discuss limited details of my case with the case management and supervisory staff of WIN and of the Network Providers in support of my care, and that such discussions will be carried out in a professional manner. I am also informed that I will be notified before any such discussion takes place and, except where limitations of confidentiality apply, I may request that specific details of my case be withheld from any Network Provider’s staff. By signing this form, I authorize such discussions between my WIN therapist and the individuals identified in this paragraph.

**CANCELLATION POLICY**

(initial) \_\_\_\_\_

I understand that I must contact my therapist’s office to cancel an appointment at least 24 hours before the scheduled appointment time. If I am unable to cancel the day before the appointment, I agree to contact the therapist on the day of the appointment, prior to the appointment time. I further understand that my therapy may be terminated if I miss two or more consecutive appointments and do not call in advance to cancel the appointments.

**EMERGENCY POLICY**

(initial) \_\_\_\_\_

I understand that WIN is NOT an emergency facility, and I will call 911 or to go to the closest emergency room if I have an emergency. If I feel I am at risk of harming myself, I understand that I should call the Suicide Hotline at (310) 391-1253 or (877) 727-4747.

I have read, understand and agree to each of the provisions of this form. I understand that I may request a copy of this form after it has been signed.

**CLIENT OR PARENT/LEGAL GUARDIAN**

**THERAPIST**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name