**CLIENT RIGHTS ACKNOWLEDGMENT**

**CLIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please print)

You received a brochure explaining your rights entitled “Client Rights and the Grievance Procedure.” A complete copy of the Patient Bill of rights, Sec. 51.61(1), Wisconsin Statutes, and/or accompanying DHS 94, Wisconsin Administrative Code, is also available upon written request. In addition, a copy of Sec. 51.30, Wisconsin Statutes, and accompanying DHS 92, Wisconsin Administrative Code, relating to your right to confidentiality is available upon written request.

If you have any questions about your rights as a client of Lutheran Counseling & Family Services, please feel free to discuss such with your therapist or contact the Clients Rights Specialist named on the back of the brochure. If you believe any of your rights have been violated, you may discuss such informally with staff, or you may submit a formal grievance with the Clients Rights Specialist. The Client Rights Specialist will provide you with a form you may use to file a formal grievance.

**SIGNATURES**

With my signature below, I acknowledge that I read or had read to me the above information. I have been notified of my rights as an individual receiving mental health treatment at this clinic and the grievance procedure available to me. I understand this information and received a copy of the brochure entitled “Client Rights and the Grievance Procedure.

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Client Date

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Parent/Guardian, if applicable Date

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Witness Date