Patient Name

DOB:

MR #

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

MINDFULNESS BASED GROUP THERAPY USER AGREEMENT

Index to Patient Participation Agreement – Behavioral Health

Date: _____

I, _____, agree to take part in Mindfulness based group therapy sessions taught by trained teachers.

I understand that:

- I am being sent to this therapy as part of my treatment plan. Other options have been shared with me (such as medicine management or individual psychotherapy). This program does not support any change in my medicines (any change in medicine must come from my health care team). I need to stay in touch with all of my health care team about my health. This is ongoing and required.
- This group does not assess thoughts about suicide or intent. If I have a hard time with either of these, I will call my doctor or therapist. If any of the practices seem to make my symptoms worse, I will tell the teacher right away.
- While research shows positive change and effects from this practice, no promise can be made about how it will affect me.
- It is meant to create more balance and ease in the body and mind. I must be willing to become aware of my senses, feelings, thoughts, and how I relate to them, which may be pleasant and/or unpleasant at any time.
- Some classes use mindful movement, yoga-based moves, and/or walking meditation. It is my job to be active within my ability. If there are physical reasons I am not able join in, it is okay to sit out during those practices.
- Being in the class requires me to being willing to be active and take part in suggested practices both in and outside of class.

AUTHORIZING SIGNATURES:

By signing, I agree that I (1) have read the above, (2), understand the form and information given by my therapist or psychiatrist, (3) have had the chance to ask questions and they have been answered to my liking, and (4) consent to the program listed above. The pros, cons, and other options have been explained to me and I agree to proceed.

Signature of Patient/Representative _____ Date: _____ Time: _____ AM/PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name:_____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent / Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor

☐ Health Care Agent ☐ Other _____

Physician Signature: _____ Print Physician Name: _____

Date: _____ Time: _____AM/PM Pager# _____

_____ _____

Interpreter or Reader Signature (if applicable) Witness Signature*

_____ _____

Print Interpreter or Reader Name Print Witness Name

_____AM/PM _____AM/PM

Date Time Date Time