Recovery Help Now, Inc.
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In-Person Consent For Treatment

Before beginning psychotherapy you should be aware of the following:

1. You have the right to decide not to receive counseling or psychotherapy from RHN clinicians. Names of other qualified therapists can be provided to you.
2. You have the right to end treatment at any time without any moral, legal, or financial obligation except for incurred fees.
3. You have the right to ask any questions about the procedures used during treatment. No procedure is to be performed without your permission.
4. You have the right to confidentiality. Within certain limits, information revealed by you during treatment will be kept strictly confidential --even the fact that you are in treatment--and will not be revealed to any other person or agency unless you give your written permission.
5. You should also know that there are certain situations in which, as health professionals, we are required by law to reveal information about you to others, without your permission. We are not required to inform you of our actions in this regard. These situations are the following:
    a) If you threaten serious bodily harm or death to another person, the law requires that the intended victim and appropriate law enforcement agency be informed;
    b) If you or someone you know abuses a child (currently or in the past) or an elderly or dependent person, the law requires that this be reported to an appropriate social service agency;
    c) If a court of law issues a legitimate subpoena; or
    d) If you are being treated or tested by courts order.
    e) If you reveal a serious intention to harm yourself, ethical standards require that, within legal limits, everything possible must be done to prevent that, including informing those in a position to help.
6. You are responsible to pay the agreed fee prior to your session for online services. You can pay for in-person services upon visit. We've made payment easy by providing secure online access to PayPal through our website. We accept some insurance carriers. Upon request we can provide you a bill so you can request reimbursement from your insurance company, on your own, if we aren't on your panel. We can't guarantee reimbursement from your insurance company. Your insurance may not cover certain procedures and we may not accept insurance for some procedures. there may be changes to fees from time to time as economic times change.
7. Every in-office client is asked to sign a Credit Card Authorization Form. Your card will not be charged without your permission. It is simply on file to protect you from any outstanding balances and avoidance of any collection agency involvement.
8. Sessions are by appointment only.
9. Occasionally, the need for an urgent phone session may arise. In that case, the fee will be calculated as minute segments. The first 10 minutes of the phone session are free. After 10 minutes the fee is $2.50 a minute.
10. Your call will be answered in the same day. If you don't receive a returned call within 24 hours, assume that we didn't get your message and call us back.

Please Print this Form and Bring to the Office on Your First Visit to: RHN, 8170 Beverly Blvd., Ste 100 A, Los Angeles, CA 90048. Fax323-951-1119.

11. If you are experiencing a clinical emergency and/or require immediate help, please call 911 or go to the closest Emergency Room facility. Please follow-up and inform your therapist of your situation.
12. Appointment cancellations or rescheduling must be made **at least 24 hours** in advance; otherwise, you are responsible for the full fee for the missed session. Group sessions operate differently. Please see group consent form for details. There are no exceptions.
13. Once you have been established as a client, emails are only used for brief correspondence (e.g., scheduling purposes or announcements).
14. We have the right to refuse to treat you if we believe that it will be unhelpful for you. In this case, appropriate referrals will be offered.
15. To create a welcoming and calm environment in our office setting, please refrain from using your cell phones in the waiting room. Please take your phone conversations outside.
16. If you have any questions regarding the above or any related issues, please mention them. If not, please indicate by your signature and the date that you have read, understand and voluntarily agree to the above conditions.

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. I _____ give permission to have my card charged if I fail to make a payment or miss an appointment. You will be notified prior to any charge.

Client Name: _____ D.O.B _____

Responsible Billing Party Name (as shown on Credit Card/Account): _____

Billing Address (as registered with Credit Card Company): _____

Phone: _____ Email: _____

Card Type (Visa or MasterCard): _____

Card #: _____ Expiration Date: _____

Three Digit Card Code (Located on Back of Card): _____

Client Signature_____ Date _____

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