

Richard Todd Rentz, LMFT

RTRSTAR, LLC
Therapy for Individuals, Couples & Families
401 Kamakee St., 4th floor Honolulu, Hawai'i 96814 (808) 800-1425
todd.rentz@gmail.com
www.richardtoddrentzlmft.com

CLIENT CONSENT FORM

CLIENT'S NAME: _____ DATE: _____

You have the right and obligation to make decisions concerning you and/or your family's care. Your therapist can provide you information and suggestions but because your treatment affects you, you should enter into the decision-making or treatment planning process. This form is designed to acknowledge your consent to service or treatment. Please feel free to ask any questions.

To assist you in making an informed decision concerning your treatment, the following will be explained to you.

- 1) The nature of the condition being treated and how it will be documented for your insurance company.
- 2) The type(s) of treatment being used, the reason(s) for such and the anticipated results.
- 3) Alternatives: the possible alternative treatments available, including a referral to another therapist or non-treatment.
- 4) No promise or guarantee has been made to you as to result or cure.
- 5) Your rights to secure a second opinion prior to the giving of consent.
- 6) The limits of confidentiality and therapist's position as a mandated reporter of abuse or self-harm.
- 7) Text and email communication is not confidential. At the client's initiation, the therapist is willing to engage in text or email conversations, with the client's full knowledge that this technology does not ensure confidentiality.

Your consent to service and treatment, once given, may be withdrawn at any time by your stating such intention to your therapist. Otherwise, your consent to treatment will expire when your treatment has been completed.

By signing below, you agree: (1) that you understand this form, (2) that the treatment and services have been explained to you, (3) that you have received all the information you want about treatment and services, (4) that you have given your permission to carry out the service/treatment plan (5) that you authorize your minor children, and other family members, to participate in services and (6) you acknowledge your right to a referral at any point in services.

Signature of client: _____ Date: _____