**Summers Counseling, LLC**

**17505 N. 79th Avenue**

**Suite 311E**

**Glendale, AZ 85308**

**(602) 684-5234**

**SummersCounseling@yahoo.com**

**Client Services Agreement**

**Professional Services:**

Summers Counseling LLC/Darlene Summers, LPC provides therapy services for individuals, couples, and families. Please review the professional fees/financial services agreement for billing rates and payment policies. Fee payment is expected at the conclusion of each session. I do not provide expert witness, expert testimony, or private family evaluation services. Additionally, I do not offer psychological assessment, testing or test interpretation. Upon request, I will provide you with referral information to a qualified professional who provides such services.

**Confidentiality Policy:**

Within the limits discussed below, the information provided to me during our professional relationship will be kept confidential and will not be breached to anyone without your written consent. However, certain conditions do require, in accordance with my professional code of ethics and the mental health laws of Arizona, that confidentiality and privileged information be disclosed under the following circumstances:

* If you present as a danger to yourself.
* If you present as an imminent danger to another person.
* If there is reason to believe that child or elder abuse is present.
* If a legitimate court order/subpoena is issued.
* If the insurance company requires information as a condition of reimbursement.

I will obtain from you a separate release of information authorization when you request or allow me to communicate with others about your therapy. However, once this information is released, please be aware that I cannot control how the information is treated. Your signature on an authorization to release/exchange information confirms your understanding that I will not be held responsible for any injury or claims for damages arising from the release of information that has been conveyed to others.

**Appointments**

Appointments with me can be scheduled by calling me personally at (602) 684-5234. In-office Sessions are scheduled for 45-50 minutes (therapeutic hour). Telephone sessions can be scheduled for clients who are traveling and cannot make office appointments. I do not provide emergency mental health/crisis counseling services. If you experience such an emergency, please call 9-1-1, or use the free mental health crisis services provided by Maricopa County by calling (602) 222-9444 or (480) 784-1500.

**Cancellation**

A 24 hour notice is required for changes in appointments. Late cancellations and no-shows incur a fee of $40. This fee is not reimbursable by an insurance company and will be charged to the credit/debit card on file the same day as the no-show or late cancel.

**Client Rights:**

* The right to receive treatment/therapy in a safe and non-judgmental environment.
* The right to refuse treatment/therapy as outlined in Arizona Revised Statutes 36.512 and 36.513
* The rights to be fully informed of Federal Confidentiality Laws, and have your records/information remain confidential, within the limits of the law.
* The right to receive impartial access to services regardless of race, religion, gender, sexual orientation, age or physical handicap.
* The right to ongoing participation in your therapy experience.
* The right to review your client file/record.
* The right to be informed, in advance of charges and services.

**Agreement/Consent to Treat:**

I have read, understand, and accept the provisions of this agreement. I understand that there are no guarantees, stated or implied, and I accept the risks inherent I the course of therapy. I understand that this agreement is binding in the State of Arizona and that the provisions are for my protection and for the protection of Summers Counseling, LLC /Darlene Summers, LPC.

Your signature below indicates that you have had the opportunity to read and review the information in this document and that questions regarding your care have been satisfactorily answered. Furthermore, it indicates your willingness to abide by its terms and that that you agree to participate in treatment. A copy of this document will be provided at your request.

Client Signature Date

Client Signature Date

Therapist Signature Date