Summers Counseling, LLC

Darlene Summers, LPC

17505 N 79th Ave Suite 311

Glendale, AZ 85308

(602) 684-5234

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**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. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

**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. Arizona law requires that I keep appropriate treatment records. You are entitled to receive a copy of your records or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with the office services. HIPPA provides certain rights and protections to you as the patient. I balance these needs with my goal or providing you with quality profession services and care. **\*Please read full HIPPA guidelines located under client forms on the website prior to your first session.** You do not need to print and bring the HIPPA form with you to your initial appointment. If you have any questions about the HIPPA form please let me know.

It is not unusual for me to consult with another licensed therapist to review cases, to do peer review and consultations. When this occurs, all identifying information about clients is removed and not included. Please ask if you have any questions about this.

**Appointments**

Appointments with me can be scheduled by calling me personally at (602) 684-5234. In-office Sessions are scheduled for 45-50 minutes or 60 minutes, whichever is deemed necessary. Tele-health sessions can be scheduled if you prefer. If so, please download the tele-health form. 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.

**Email, Text Messaging and Social Media**

While email and text messaging have become primary modes of communication, it is important to identify that they are neither secure nor confidential means of communication. Communicating organization needs such as scheduling, rescheduling or cancelling an appointment can be made via email, text message or phone however, please do not send me **content** related to your therapy session via email or text as it is not confidential. By signing this consent form you agree to allow appointment confirmations be sent to your cellphone or email. If you do not agree to this, please make a note of this at the bottom of this form with your initials. Also, I do not accept friend or contact requests from current or former clients on any social networking sites . I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this please bring them up when we meet and we can talk more about it.

**Cancellation**

A 24 hour notice is required for changes in appointments. Late cancellations and no-shows incur a fee of $50.00 for the first occurrence and $100 for the second and beyond. 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 in 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.

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize my therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop care at any time. I acknowledge that I have read and understand my HIPPA rights and consent for treatment.

Client Signature Date

Client Signature Date

Therapist Signature Date