Monika Summerfield, MA
Licensed Marriage & Family Therapist # 41527
16052 Beach Blvd. Suite 212, Huntington Beach, CA 92647, T.714 745 3238

OFFICE POLICIES AND CONSENT FOR TREATMENT

Welcome. Our intention is to provide you with high quality professional therapy services. Please read, complete, and sign this Consent for Treatment and New Client Information:

1. Consent for Treatment

1.1. I give my consent to Monika Summerfield, LMFT to provide me, my child and/or my family with psychotherapeutic care. If my child is being treated, I understand that treatment is contingent upon parental/guardian participation if such is considered necessary.

1.2. This consent is valid until 6 months after termination of services.

2. Confidentiality

In order to protect my best interests and rights these are the circumstances that are exceptions to confidentiality according to California State Law.

2.1. Reasonable suspicion or evidence that a child, elder or dependent adult is being sexually or physically abused or neglected. A call to Child Protective Services / Adult Protective Services may be required.

2.2. In cases of threatened suicide, the therapist has a legal duty to take reasonable steps to ensure the safety of the client.

2.3. If a client communicates a serious threat of physical violence against a reasonable identifiable victim/s.

2.4. Upon receipt of a court order/subpoena.

2.5. In the event of a valid emergency.

2.6. To the "non-custodial" parent in case where there is legal joint custody.

3. Attendance Policy

I agree to attend the scheduled appointments. I understand that if I need to reschedule or cancel my appointment a 24-hour notice is required in order to waive the fee of $ **80**.
For my convenience outstanding charges can be covered through the charge card on file.

4. Fees

Fees are payable at each session by check, cash or credit card. The standard fee is $ 150 for a **50 min. session**. A sliding scale fee may apply. I understand that my set fee is $_____.
I remain responsible for any charges not paid by my insurance or outside provider. It is my responsibility to assure my coverage through my health insurance. Insurance session length is **45 min**. My co-pay is $ _____.
For longer sessions (EMDR) fees are calculated by the increment of time needed for treatment. The 80 minutes standard fee is $ 190. For 90 minutes the fee is $ 200.

Additional services such as crisis intervention, assessments, letters and reports are charged separately. Any balance over 30 days may be subject to finance charge. If my check is returned, my account will be charged a $ 10 returned check charge.

5. Emergencies

In case of emergency I can leave a message on the following confidential voice mail number: (714) 745-3238.
After hours if needed, I will contact 911 or go to my nearest emergency.

6. Privacy and Communication Preferences

This psychotherapist can be contacted either by phone, text or by email. (monika@monikasummerfield.com)

These are my communication preferences:

Cell Phone: _____ Okay to leave voice message? Yes ___ No ____

Home Phone _____ Okay to leave voice message? Yes ___ No ____

Work Phone_____ Okay to leave voice message? Yes ___ No ____

Email _____ Okay to leave email message? Yes ___ No ____

7. Card Authorization

In the event that I have a negative balance accrued, I authorize the entity Monika Summerfield, LMFT the use of my charge card to settle any outstanding payment. This could be due to either my check being cancelled, my outside provider not paying for the services, a missing co-pay or failure to cancel appointments. In this case, I will receive prior notification.

Card Type: (circle one) Visa MasterCard Discover

Card #: _____Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back by signature line) _____ Zip Code_____

I reviewed and accept the conditions of treatment

CLIENT _____ DATE _____

PARENT/ GUARDIAN _____ DATE _____

WITNESS _____ DATE _____