

Gina Candelaria, M.Ed., M.C., LPC

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PURPOSE OF TREATMENT

I, _____ understand that Gina Candelaria,
Licensed Professional Counselor, will provide Psychological Counseling for
myself/my child _____.

(Circle one)

(Name of Client)

I further understand that this provision of care does **not** include offering to give
testimony in court, complying with attorney-generated subpoenas or any form of
voluntary waive of privilege.

There is no expiration for this agreement. I understand and agree to these terms
by signing below.

(Client/Parent)

(Date)

(Client/Parent)

(Date)

(Witness)

(Date)