\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome

Thank you for coming in to meet regarding your child or teen. Please take a few minutes to read and complete this registration packet. It includes:

1. Cover Page for general personal information

2. Informed Consent (2 pgs.) to give you important information about therapy, office policies, etc. – Read, initial and sign

3. Authorization to Treat a Minor (1 pg.) --Read and sign

4. No Subpoena Agreement –Read and Sign

5. PLEASE Make Copies of Forms–Keep for your Records

Also, I invite you to look at my website: www.therapybythesea.net for helpful information and directions to the office. I look forward to meeting with you.

Deborah

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT REGISTRATION

Parents, complete parent information section at bottom of this page

CHILD’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Gender M / F

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Required for insurance)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to leave message? Home yes / no Cell yes / no

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_

Time school day is done \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Doctor or Psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Medical Issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings living with client full-time (Names/Ages) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others living in the home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weekly Activities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Interests/Hobbies/Sports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pet(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other important information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PARENTS or GUARDIANS INFORMATION****:*

|  |  |
| --- | --- |
| ***Mother***Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Required for InsuranceHome Tel #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell/Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave message? Home Yes / No Work Yes/NoEmployer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Residence of Child? Yes NoStep Parent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Father***Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Required for InsuranceHome Tel #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell/Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave message? Home Yes / No Work Yes/NoEmployer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Residence of Child? Yes NoStep Parent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

GUARDIAN (If different from parent) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Required for insurance)

Address if different from minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to leave message? Home yes / no Work -yes / no Cell yes / no

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT -THERAPIST AGREEMENT / INFORMED CONSENT**

Please read the following carefully. If you have any questions do not hesitate to discuss them.

**CONFIDENTIALITY**

Your appointment and the contents shared during that time are held in confidence. This includes all file notes, personal information provided and/or data collected during treatment. No disclosures will be made without your written permission. I do not conduct therapy via email. However, there are times when it may be appropriate to exchange information via email and you should do so only with awareness of the limitations and risks inherent in electronic communication.

Please read the circumstances, below, under which I will not, or may not keep information confidential

.

**Exceptions and Limits to Confidentiality:**

California State Law mandates reporting to authorities in the following circumstances:

* Incidents that involve child, dependent adult or elder abuse; including neglect, physical, sexual abuse or unjustifiable mental suffering.
* Disclosures of intent to harm another person

.

California State Law permits breaking confidentiality in the following circumstances:

* Incidents that involve emotional and/or psychological abuse of a dependent adult or elder.
* Indications of client being a danger to self, others or property

**APPOINTMENTS ~AVAILABILITY ~ THERAPY PROCESS**

The length of a standard session is 50 minutes. Arrangements can be made for longer sessions for family and/or conjoint appointments, or when appropriate for individual clients. Fees and the length of these sessions will be discussed prior to scheduling any special appointments.

A telephone answering system is available 24 hours for messages and I normally return calls the same day. When I am not available (i.e., conferences, vacations), my message will provide the name and telephone number of an on-call therapist. **If you experience a life-threatening emergency, call 911 or go to the nearest hospital emergency room.** Please be aware that email may not be reliable for scheduling/rescheduling appointments

The client-therapist relationship is a collaborative working partnership established and maintained by mutual trust and respect. As your therapist, I commit to provide you professional services within my scope of practice and competence. If, at any time, I determine that another professional might better serve you, I will make the necessary referrals and/or resources available to you. It is my intention to provide services that will assist you in reaching your goals. Based on the information you provide and the specifics of your situation, I will give you feedback and provide recommendations regarding treatment. You have the right to agree or disagree and are responsible for making your own decisions.

The therapy process involves certain risks and benefits. Due to the varying nature and severity of problems and the individuality of each client, it is not possible to predict or guarantee a specific outcome or result of therapy.

Deborah Phillips, MFT is an independent, sole-proprietor and provides services only through her own private practice. No one else is legally connected to or responsible for the work of Deborah Phillips.

 **\_\_\_\_\_\_ Initial** **\_\_\_\_\_\_ Initial**

**CANCELLATIONS / RESCHEDULING**

I appreciate as much notice as possible when you need to cancel or reschedule an appointment. Appointments must be cancelled 24 hours in advance in order to avoid charges.

It is understood that emergencies arise. If something unexpected does arise, please phone as soon as possible so that we can reschedule your appointment.

 **\_\_\_\_\_\_ Initial** **\_\_\_\_\_\_ Initial**

**FEES / PAYMENT**

As the client, you are fully responsible for payment of all services rendered. Payment is due at each session unless other arrangements have been made. Charge for cancelled sessions when less than 24 hours notice is given is $50.00, and can be mailed or brought to the next appointment if less than one week away. The fee for service will remain constant unless notified of a change 30 days prior to the change.

**Insurance:**

**Please note: I do not bill insurance directly, but will be happy to provide you with a monthly statement of services (“superbill”) for you to submit to your insurance company. Payment is due at the time of service and your insurance company will reimburse you according to your policy.**

**FEES FOR SERVICES RENDERED:**

Please remember that cancellations must be made at least 24 hours in advance to avoid being charged for the missed appointment. Please make payment at the beginning of your session (credit card, cash orcheck - payable to Deborah Phillips)**.** Additional fees will be charged for telephone counseling in excess of 15 minutes, letters, reports and legal-related matters.

 **\_\_\_\_\_\_ Initial** **\_\_\_\_\_\_ Initial**

**Type of Session/Fee**

Standard Individual Session (50 min) $120.00

Standard Couple or Family Session (60-90 min) $150.00

Cancelled sessions when less than 24 hours notice is given $50.00

Missed sessions with no notice (“No-show”) Full Fee

Longer session must be prearranged, charges will be discussed at that time.

Document preparation $150.00 per hour + $.15/copied page + postage/handling.

Between session telephone counseling/contact (No charge for calls 15 min. or less) $25.per each 15 min.

 **\_\_\_\_\_\_ Initial** **\_\_\_\_\_\_ Initial**

.

**Notice of Your Right to Receive a Good Faith Estimate**

You have the right to receive a “Good Faith Estimate” to help you estimate the expected charges you may be billed. **\_\_\_\_\_\_ Initial** **\_\_\_\_\_\_ Initial**

I have had the opportunity to discuss this informed consent statement with my therapist, Deborah Phillips. I understand its meaning and consent voluntarily to receiving services based on this understanding.

SIGNATURES

:

Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name)

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name & Relationship)

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name & Relationship)

PARENTAL CONSENT TO TREAT A MINOR

Please read the following carefully. If you have any questions do not hesitate to discuss them.

CONFIDENTIALITY

Minor’s Right to Confidentiality

Children and adolescents (under 18 years) have the same legal right to confidentiality as adults. Please understand that your child’s appointment and the contents shared during that time are held in confidence. This includes all file notes, personal information provided and/or data collected during treatment. NO disclosures will be made without written permission. As your child’s therapist, I appreciate the importance of parents’ concern and involvement, and will discuss the kinds of information that will and will not be kept confidential.

**Exceptions and Limits to Confidentiality**

California State Law mandates reporting to authorities in the following circumstances:

♦Incidents that involve child, dependent adult or elder abuse; including neglect, physical, sexual abuse or unjustifiable mental suffering.

♦Disclosures of intent to harm another person

.

California State Law permits breaking confidentiality in the following circumstances:

♦Incidents that involve emotional and/or psychological abuse of a dependent adult or elder.

♦Indications of client being a danger to self, others or property

 Initial \_\_\_\_\_\_ Initial \_\_\_\_\_\_

PAYMENT

Payment for services provided to a minor is considered the responsibility of the parent(s) that has requested treatment. If you and your child’s other parent are sharing the cost of treatment, please make arrangements to fulfill that agreement prior to the appointment. The full fee is due at the time of each session and should be paid by the parent who accompanies the child, unless other arrangements have been made.

**IF YOU ARE SEPARATED OR DIVORCED FROM YOUR CHILD’S OTHER PARENT:**

1) Do you have? Legal Custody: \_\_\_ Joint\_\_\_ Sole (Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Physical Custody:\_\_\_ Joint\_\_\_ Sole (Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

2)Is there a court document (legal agreement) that requires the consent of both parents for mental health services?\_\_\_ Yes \_\_\_ No

3) Can you provide me with a copy of the document?\_\_\_ Yes\_\_\_

NAME OF MINOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURES:

Minor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Mother’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Father’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Important Notice of Agreement

For Parents Who Are Divorced or Separated

In order to effectively help your child, it is important for me to have open communication with both parents. This may be in the form of telephone consultations, office appointments or written communication. There may be times when I request a joint meeting with both parents, with or without your child present. It is my expectation that, if asked, both parents will be willing to come together in a respectful manner with the intention of supporting the goals of treatment for your child. (Unless a different agreement is made between parents, it is expected that each parent will pay for one-half the cost of a session where both parents are present.) Children adapt and function best, following separation or divorce, when parents are able to develop cooperative and appropriate co-parenting roles.

If there is anything you feel is important for me to know before an appointment, please leave a message on my voice mail prior to our scheduled appointment time. Any information divulged to me by either parent *that* *directly involves or affects your child* may be shared with the other parent. This means that I will not keep secrets or withhold information from the other parent when it relates to something that, in my clinical judgment, could affect the welfare of your child and/or interfere with treatment. I understand that communication between parents may be strained and I will be sensitive to this. My intention is to keep the therapy focused on issues that relate to your child’s welfare and your role as parent and co-parents. I look forward to supporting all of you in this goal.

Your signature acknowledges that you have read and understand the above. Please feel free to discuss any questions or concerns you may have now, or at any time.

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NO SUBPOENA AGREEMENT**

**Due to the nature of the therapeutic process and the fact it often involves disclosing information with regard to many matters which may be of a personal and confidential nature, I agree that neither I nor my attorney nor anyone else acting on my behalf will call on Deborah Phillips, MA, LMFT:**

* **To become a witness to testify in court, at depositions or any other legal proceeding**
* **To disclose client psychotherapy records**
* **To communicate with child custody evaluator/s or other representatives of the court**

**I understand the reason for this agreement is that the purpose and interests of the courts may not be in the best interests of, and may interfere with, my own therapeutic work.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Name (print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Name (print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian’s Name (print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**