



Co-Parenting Packet

Co-Parenting vs. Parenting Coordination

Co-parenting:

- Occurs either before the divorce is finalized or after the divorce
- The therapist does not have decision making authority in settling disputes
- The therapist has no specific time limit for the role
- The therapist often focuses on developing the parenting plan or working out conflicts with regard to the interpretation of the parenting plan

Parenting Coordination:

- The therapist has the authority either by Consent Order or Court Order to resolve disputes
- The therapist is appointed *after* the divorce is finalized
- Usually has a time limit of 2 years with options to renew
- The therapist has the authority to talk to other parties like the school system, daycare workers, etc. as needed in formulating the decisions
- The therapist generally presents the decisions in writing

In common:

- Neither are confidential processes
- Both may involve meeting with the children
- Both are not covered by HIPAA
- Both involve required training and experience but are not considered therapy
- Both parents must sign the forms designated co-parenting/parenting coordination on the website

This packet includes:

- Co-Parenting Agreement -- completed as directed by Dr. Wert
- Adult Registration Form -- for clients 18 years and older
- Informed Consent to Treatment Agreement -- completed by all clients
- Co-Parenting Addendum Consent for Treatment

Northside/West End Office 5821 Staples Mill Road
Richmond, Virginia 23228-5427
(804) 264-0966
Fax: (804) 264-1029

Southside Office
1241 Mall Drive
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(804) 794-5928
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ADULT REGISTRATION FORM

All Information will be treated confidentially

Today's Date: _____

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home () _____ Work: _____ Cell: _____

SSN#: _____ Email: _____

Age: _____ Birth Date: _____ Gender: _____ Marital Status: _____

Occupation: _____ Highest Education Level: _____

Employer: _____

In Emergency, notify: _____ Telephone: _____

Who referred you to us?: _____

Physician's Name and Number: _____

If you believe your insurance may cover part of these costs, and you would like this office to file insurance, we will need the following information:

Is this an EAP (Employee Assistance Program) visit? Yes No
Does your insurance require pre-authorization? Yes No

Subscriber's Name _____ Date of Birth _____ Employer _____ ID Number _____

Primary Insurance Company _____ Address _____

Secondary Insurance Company (if any) _____ Subscriber's Name _____ Date of Birth _____ ID Number _____

Date of Last Doctor's Visit: _____ Purpose: _____

Current or Chronic Illnesses? _____

Current Medications? _____

Current Physical Health: Good Fair Poor

If you have ever received a mental health evaluation or treatment, please indicate the following:

_____ Date Began: _____ Date Ended: _____

Therapist's Name and Address

Personal Symptoms History

Check any that apply to you now. Place a P by those that have been a problem in the past but are not a problem now.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Past Suicidal Attempts | <input type="checkbox"/> Chronic Medical Problems | <i>Addictive Behaviors:</i> |
| <input type="checkbox"/> Insomnia/Sleep Problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Significant Childhood Illness | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Feel Tense | <input type="checkbox"/> School Problems | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Work Problems | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Sexual Addiction |
| <input type="checkbox"/> Can't Make Decisions | <input type="checkbox"/> Excessive Fears | <input type="checkbox"/> Legal Problems | |
| <input type="checkbox"/> Low Self Esteem | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Marital Problems | <i>Other:</i> |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Relationship Problems | |
| <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Over Ambitious | <input type="checkbox"/> Physical Abuse | |
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Overly Suspicious | <input type="checkbox"/> Emotional Abuse | |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dislike Weekends/Holidays | |
| <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Family Conflict | |
| <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Recent Loss | |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Seizures | <input type="checkbox"/> Childhood Trauma | |
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Disorientation | <input type="checkbox"/> History of Sexual Abuse | |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> History of Sexual Assault | |
| <input type="checkbox"/> Sexual Preoccupation | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Flashbacks | |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Hallucinations | |

Major reason for seeking help at this time: _____

Please add any information that you feel may be helpful to us: _____

Medical History: (check all that apply)

Appetite Disturbance _____ Sleep Disturbance _____ Seizures _____

Head Trauma _____ Allergies _____

Other? _____

Hospitalizations? _____

Previous Mental Health-Related Medications? _____

Side Effects? _____

Please circle any of the following that have been present in the family (including the extended family on both mother's and father's side):

- Obsessive-Compulsive Disorder
- Depression
- Learning Disabilities
- Uncontrolled Anger
- Eating Problems
- Suicide
- Attention-Deficit/Hyperactivity Disorder
- Schizophrenia
- Bi-Polar Disorder
- Hospitalization for treatment of mental illnesses
- Sexual Abuse
- Physical Abuse
- Social Fears

Addictive Behaviors:

- Drug/Alcohol Abuse
- Gambling
- Sexual Addiction
- Other: _____

Please elaborate on an of the above: _____

Any history of academic difficulties? Yes No If "Yes", please describe them:

Any other relevant Family History: _____

Please list others who live in your home(siblings, spouse, etc.): _____

Note: An initial evaluation is \$150 for a 45/50-minute session. Payment (or copayment if using insurance) is requites at the time of service. If you wish to make other arrangements, please discuss them with your therapist at your first appointment.

_____ Date

_____ Signature of Person Responsible for Payment

INFORMED CONSENT TO TREATMENT AGREEMENT

As your mental health professional, I will disclose no information obtained from your contacts with me or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law:

1. It is my policy to provide information to others without your further consent, in certain circumstances:
 - a) Harm to Yourself or Someone Else. (If I believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for insuring your safety or the safety of others.)
 - b) Vacations and Emergencies. (When I am on vacation or away from the office for extended periods of time, a colleague may cover for my practice and take emergency calls. If she/he will need information in order to assist you in my absence, I will provide it without using your full name; you and I will discuss that plan in advance.)
 - c) Consultation. (To insure that I am providing quality care, I sometimes meet with a consultant. In so doing, I do not reveal identifying information. I will provide names of my consultants upon request.)
 - d) Answering Service. (On nights and weekends, I use the Hello, Inc. Answering Service. They understand my confidentiality policies, and after paging me they will keep no record of your name or phone number.)
 - e) Billing Service. (The Westwood Group office staff has access to the information necessary for preparing monthly statements and submitting insurance claims.)
 - f) Partners and Employees. (My office partners do not have access to my records. However, we share a clerical staff which takes messages when the office is open.)

2. Virginia law requires psychologists to release information to others in certain circumstances:
 - a) Virginia therapists are required by law to report certain information:
 - 1) Suspicion of abuse or neglect of a child or of an aged or incapacitated adult must be reported to the Board of Social Services.
 - 2) Information that a Psychologist is engaging in unethical or illegal practice must be reported to the Board of Psychology.
 - 3) If you are licensed by a Health Regulatory Board, I am required to report that you are receiving therapy if I believe that your condition places the public at risk.
 - b) Virginia law imposes upon therapists the legal duty to protect other members of society from harmful actions by their patients. Voiced threats of direct harm to another person can result in notification of the potential victim, law enforcement officers, and/or others as specified by statute.
 - c) In Virginia court cases, therapist-patient privilege may not apply in certain cases, including:
 - 1) criminal cases
 - 2) child abuse cases
 - 3) any court case in which your mental health is an issue, and/or
 - 4) any case in which the judge “in the exercise of sound discretion deems it necessary to the proper administration of justice.” This means that information communicated to a therapist can be admitted as evidence in a court case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either treatment records or testimony from your present or former therapist as evidence in a court case (including child custody cases). If I receive such a subpoena, I will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash the subpoena and requesting that the confidentiality of the therapy relationship be protected. However, only the judge may decide whether or not the requested information or records must be disclosed.
 - d) Virginia law allows certain others to request access to treatment records in specific circumstances, including
 - 1) Protective Service Workers to whom I have reported suspicion of abuse or neglect, if they so request;
 - 2) Court-Appointed Special Advocates in child abuse or neglect proceedings, if the court so orders and
 - 3) Evaluators for minors’ involuntary commitment to inpatient treatment, if they so request.

In such cases, I will make every attempt to limit the information disclosed by substituting an oral or written report rather than submit actual treatment records.

- d) If you are under 18, Virginia law allows your parents to obtain information and/or records related to your treatment. There is an exception to this if you are in treatment for drug or alcohol abuse (substance abuse).

3. Information will be provided to third party payers, i.e., insurance companies, only with your consent:

If you wish to obtain third party reimbursement for mental health services, certain information must be provided. You must decide whether to give consent for me to release the necessary information to an insurance company (or other third party payer) in order to receive reimbursement. Initially, that usually involves providing information about dates of treatment, type of treatment, and nature of your problem (diagnosis). If I receive requests for further information, these will be disclosed with you before the information is provided.

Regarding Managed Care Insurance:

If your insurance company contracts with a company to administer (manage) the mental health portion of your health care benefits, this is called managed care. Many managed care companies require that you obtain a referral from your primary care physician and/or pre-authorization from a case manager in order to receive mental health services. In advance, (1) we will discuss possible limits on the benefits available through your plan; (2) we will review a Treatment Plan so that you understand what information I would be required to submit in order to request authorization for your treatment; and (3) we will discuss the payment plan that will be in effect in the event that our work together continues past the point when third party authorization/reimbursement is no available.

Most managed care companies initially authorize a limited number of sessions, then require that I complete a form (Outpatient Treatment Plan) pertaining to your presenting issues, your diagnosis, a brief description of your current situation, and goals for our work together. If additional sessions are authorized, updated Treatment Plans about your progress may be required throughout our work together; we will discuss the content of each Treatment Plan before it is sent to the managed care company.

As a consumer of mental health services, you need to know that the information provided to any third party becomes a permanent part of your file with them, and that neither you nor I will have control over the further confidentiality of that information, including whether it is made available to an insurance data bank and/or your employer or is re-released for other purposes.

DOCUMENTATION OF PATIENT AUTHORIZATION:

I understand that if I receive mental health services from Dr./Mr. /Ms. _____ the above limitations may be imposed on confidentiality. I hereby accept those limits of confidentiality and consent to receive treatment under those conditions.

I do ____ do not ____ give consent for claims to be submitted for third-party/insurance reimbursement..

PATIENT/ /PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

CO-PARENTING ADDENDUM

CONSENT FOR TREATMENT

Court Involvement:

Because you are seeking help in a situation where the Court may be involved, please be aware that these records may be subpoenaed by the Court or by one of the attorneys involved in the case. Please address any concerns you may have about these issues at any point during your work with me.

Confidentiality:

Because of the nature of this therapy, there is a possibility that I may be subpoenaed to Court. As a result, confidentiality is limited to the degree that this may occur, especially as it pertains to your children and/or your cooperation in the co-parenting process. By signing this release, you are NOT waiving your rights to confidentiality. This is simply a notification that our discussions and my professional opinion may be subpoenaed to Court.

Case Consultation:

Due to the difficult nature of co-parenting therapy, I may seek consultation with my peers if applicable. Any identifying information will be removed from the case material. If you have any questions about this consultation, please do not hesitate to ask.

The following outlines my fees for any Court related services. Please be advised that by signing this document, you are agreeing to pay for these services in full should you decide to exercise them.

1. Co-parenting sessions are approximately 45-50 minutes in length. The initial session is \$200.00. 90-minute sessions are \$300.00 and two-hour sessions are \$400.00.
2. Email and phone calls on topics other than setting up appointments are billed at the rate of \$50.00 per 15-minute increments.
3. Conversations with the children's therapist and/or the Guardian ad litem are not charged. However, any conversations with attorneys are billed at the rate of \$50.00 per 15-minute increments. If the attorney has asked for a block of time for this discussion, you will be billed for that entire time regardless of how long the phone call occurs because I have had to block off this time for the phone contact.
4. Preparation for Court, reports and/or letters, attendance at pre-trial conferences or dispositions, and telephone conferences are all billed at the rate of \$200.00 per hour in 15-minute increments. Any travel time is billed at the same hourly rate.
5. Copying charts are charged at a rate of .50 cents per page plus a \$20.00 handling fee.
6. Court is charged at a rate of \$250.00 per hour. This fee will also include travel to and from Court, time waiting, as well as time in the actual courtroom. A deposit is required for attendance at court.

_____ Initials

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CONSENT FOR TREATMENT

7. For settlements or continuations in which I have not been given 48 hours notice, I will bill for the time blocked off for Court at the rate of \$150.00 per hour.
8. Sometimes due to the complexity of a case, I will request a deposit, which is due at the first appointment. If requested, the deposit expected from you today is: _____.
9. If there is an agreement which designates the percentage split of costs associated with co-parenting sessions, then we will follow that agreement. Otherwise, the split will be 50/50. Any other expenses will be born by the party initiating the request and/or subpoena.
10. Missed appointments shall be paid for by the party who has not given 24 hour notice. The charge for missing co-parenting sessions is \$150.00.
11. There will be a \$25.00 charge for all returned checks. You are responsible for these charges.
12. A service charge of 18% APR will be added to bills that are 90 days past due. If you fail to settle your account, it will be referred to a collection agency and you will be charged for the additional cost of collection, approximately 33 1/3% of the balance due plus court costs.
13. Recording of sessions is forbidden.
14. As your mental health professional, I will disclose no information obtained from your contacts with me or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law:
 - a. Harm to Yourself or Someone Else. If I believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for insuring your safety or the safety of others.
 - b. Vacations and Emergencies. When I am on vacation or away from the office for extended periods of time, because of the complexity of this work, there is no back up clinician access because it is too difficult for someone to intervene who is unfamiliar with your family. If you are unable to reach me, you will need to use other resources like the GAL (if applicable), your attorney etc.
 - c. Consultation. To insure that I am providing quality care, I sometimes meet with a consultant. In so doing, I do not reveal identifying information. I will provide names of my consultants upon request.
 - d. Answering Service. On nights and weekends, I use the Hello, Inc. Answering Service. They understand my confidentiality policies, and after paging me they will keep no record of your name or phone number.

_____ Initials

CO-PARENTING ADDENDUM CONSENT FOR TREATMENT

- e. Billing Service. The Westwood Group office staff has access to the information necessary for preparing monthly
- f. Partners and Employees. My office partners do not have access to my records. However, we share a general secretary who takes messages when the office is open.

Signature

Date

Signature

Date

Witness

Date

_____ Initials