The Westwood Group
Established 1983

Parenting Coordination 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:

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

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

Southside Office
1241 Mall Drive
Richmond, Virginia
(804) 794-5928
Fax: (804) 379-6385

ADULT REGISTRATION FORM

All Information will be treated confidentially

Today's Date _____

Patient's Name _____

Address _____

City _____ State _____ Zip Code _____

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

SS# _____ 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 Subscriber's Date of Birth Subscriber's 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 problems in the past but are not problems now.

___ Depression
___ Insomnia/Sleep Problems
___ No Appetite
___ Fatigue
___ Irritable
___ Can't Make Decisions
___ Low Self Esteem
___ Mood Swings
___ Inferiority Feelings
___ Anger Problems
___ Hyperactivity
___ Violent Behavior
___ Compulsive Behavior
___ Overeating
___ Weight Problems
___ Sexual Problems
___ Sexual Preoccupation
___ Suicidal Thoughts

___ Past Suicidal Attempts
___ Anxiety
___ Feel Tense
___ Constant Worrying
___ Panic Attacks
___ Excessive Fears
___ Withdrawn
___ Excessive Guilt
___ Over Ambitious
___ Overly Suspicious
___ Headaches
___ Dizziness
___ Fainting Spells
___ Seizures
___ Disorientation
___ Memory Problems
___ Stomach Problems
___ Nightmares

___ Chronic Medical Problems
___ Significant Childhood Illness
___ School Problems
___ Work Problems
___ Financial Problems
___ Legal Problems
___ Marital Problems
___ Relationship Problems
___ Physical Abuse
___ Emotional Abuse
___ Dislike Weekend/Holidays
___ Family Conflict
___ Recent Loss
___ Childhood Trauma
___ History of Sexual Abuse
___ History of Sexual Assault
___ Flashbacks
___ Hallucinations

Addictive Behaviors:
___ Alcohol Abuse
___ Drug Abuse
___ Gambling
___ Sexual Addiction

Other:

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):

Obessive-Compulsive Disorder Depression Learning Disabilities Uncontrolled Anger

Eating Problems Suicide Attention-Deficit/Hyperactivity Disorder Schizophrenia

Bi-Polar Disorder Hospitalization for treatment of mental illnesses Anxiety

Sexual Abuse Physical Abuse Social Fears

Addictive Behaviors:

Drug/Alcohol Abuse Gambling Sexual Addiction Other:

Please elaborate on any 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: The charge for an initial evaluation is $150 for a 45/50-minute session. Payment (or copayment if using insurance) is requested 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

PARENTING COORDINATOR ADDENDUM
CONSENT FOR TREATMENT

Court Involvement:

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

Confidentiality:

Because of the nature of this work, there is a possibility that I may be subpoenaed to Court. As a result, confidentiality is not present in the parenting coordination process, especially as it pertains to your children, the decisions made in this process and/or your cooperation in this process.

Case Consultation:

Due to the difficult nature of parenting coordination, 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.

Process for decision making:

Whenever possible, I will make decisions based upon joint meetings with the parties. However there may be times when I must make a decision based upon phone conversations, e-mails or other sources of information. In addition, if there is a deadline and one party does not make themselves available, I will make a decision based upon the information that is available. These decisions are binding. All of the decisions will be written when necessary. However there is a charge for the writing time involved.

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.

_____ Initials

_____ Initials [Type text]

PARENTING COORDINATOR ADDENDUM
CONSENT FOR TREATMENT

1. Parenting Coordination sessions are generally 90 minutes in length and are billed at a rate of 300.00 per session. Two hour sessions are billed at the rate of 200.00 per hour.

2. E-mail and phone calls on topics other than setting up appointments are billed at the rate of 15 minute increment at the standard hourly rate of 200.00 per hour.

3. Preparation for Court, reports and/or letters, attendance at pre-trial conferences or dispositions, 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.

4. Copying charts are charged at a rate of .50 cents per page plus a $20.00 handling fee.

5. Court is charged at a rate of $200.00 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.

6. 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 $100.00 per hour.

7. Due to the degree of out of session work involved in parenting coordination, I request a deposit which is due at the first appointment. The deposit expected from you today is: _____

8. If there is an agreement which designates the percentage split of costs associated with parenting coordination work, then we will follow that agreement. Otherwise, the split will be 50/50.

_____ Initials

_____ Initialsext] [Type text] [Type text]

9. Missed appointments shall be paid for by the party who has not given 24 hour notice. The charge for missing the session is 150.00. If the topic to be discussed has a deadline that makes a decision critical, the session may go forward and a decision may be made without the other party.

10. Recording of sessions is forbidden.

11. **Grievance process:**

At some point you may feel that the recommendations are unfair. You are welcome to discuss these feelings with me. However it's important to remember that the focus of these recommendations is based upon what is in the best interest of the child. As a result, this focus may not be in line with what you want/or feel is important at times. If at some point, you decide that you no longer want to continue working with me, then you and the other parent can mutually agree to seek another parenting coordinator. In addition, you can ask the Court to appoint another parenting coordinator. I will need to continue working in this role until the new appointment occurs. If I feel that I am unable to continue in this role, then I will give you recommendations of other people trained in parenting coordination. In general, I will only serve in this role in 2 year increments which all of us can agree to renew again in 2 year increments.

12. There will be a $25.00 charge for all returned checks. You are responsible for these charges.

13. 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.

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:

PARENTING COORDINATOR ADDENDUM
CONSENT FOR TREATMENT

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.

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

_____ Initialsext] [Type text] [Type text]

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. /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 _____