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]

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1. Parenting Coordination sessions are generally 90 minutes in length and are billed at a rate of 300.00 per session. Two hour and one 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 1 year increments which all of us can agree to renew again in 1 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:

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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]

FINANCIAL AGREEMENT

- The Westwood Group's therapy fees are as follows:
  - 45 min. Initial Evaluation session $150
  - 45 min. Individual Therapy session for adults $125
  - 45 min. Individual Therapy session for children and adolescents $135
  - 45 min. Family or Marital Therapy session $135
- If you would like to use your health insurance, you need to call the number on your insurance ID card and fill in the Insurance Benefits Form, included with this set of forms, before your first session and bring it with you. This will instruct you to confirm that your therapist is covered by your insurance plan and to obtain pre-authorization of services, if necessary. It will also help you determine if there is an annual deductible amount to be met before coverage starts each year, and if you need to pay a copayment (which is a fixed amount due at each session) or coinsurance (which is an amount based on a certain percentage of the allowable charge for each session).
- Payment of the client's portion of the fees is due at the time of service. This may be made in the form of check, cash, or credit card.
- There is a $75 charge for missed appointments or appointments cancelled less than 24 hours in advance. This notice is needed in order to reschedule the appointment time with another client. This charge is not covered by insurance policies.
- The cost of psychological evaluation/testing varies with the tests administered and will be explained by the examiner prior to testing.
- Services not covered by health insurance include sessions exceeding 50 minutes, court testimony, letter- and report-writing, phone calls lasting more than 5 minutes, and authorized contact with other professionals, including attorneys, teachers, physicians, and therapists. These services will be discussed with the client in advance, and are usually prorated on the time involved, based on an hourly rate set by your therapist.
- There is a $35 charge for all returned checks.
- A service fee of up to 10% per month will be added to any bill that is 90 days past due. If referral to a collection agency is necessary, an additional charge of up to 50% of the balance will be added to cover the cost of collection and any court costs.
- Credit Card on File Program: The Westwood Group requests that you keep a credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, as well as any other services or fees for which you are responsible. This agreement is included with this set of forms.

I have read the above terms and accept treatment under them.

Date: _____

Printed name of client or person responsible for payment_____

Signature of client or person responsible for payment _____

THE WESTWOOD GROUP
AGREEMENT TO PARTICIPATE IN CREDIT/DEBIT CARD ON FILE POLICY

Your provider requests that you keep a credit or debit card on file (which is kept confidential in accordance with HIPAA standards and regulations at all times) as a convenient method of payment for the portion of services that your insurance does not cover, as well as any other services or fees for which you are responsible. Your signature authorizes your provider to charge this card for the any remaining balance for services as outlined in the Financial Agreement.

Before your card will be charged, you will receive a mailed invoice itemizing the charges. These expenses will be applied to your card after a minimum of 10 business days from the time the invoice is sent out. Unless you have made arrangements with our billing office for a payment plan your card will be charged the full amount of any remaining balance due. Requests for payment plans must be made in writing to our billing office and approved by your provider at the address below.

The Westwood Group
5821 Staples Mill Rd.
Richmond, VA 23228

I _____authorize my provider to charge the portion of my bill that is my financial responsibility to the following credit or debit card: I understand that my information will be saved to file for future transactions on my account.

☐Visa ☐ MasterCard ☐ American Express ☐ Discover
Card Number: _____
Expiration Date: _____ / _____ / _____
CCV Code on back of card: _____
Name as it appears on card: _____
Credit Card Billing Address Street Name and Number: _____
City: _____ State:_____
Zip Code (from credit card billing address): _____.

I (we), the undersigned, authorize and request my (our) clinician to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for psychological services. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to our billing office in writing and the account must be in good standing.

Card Holder Name (Print): _____
Card Holder Signature: _____
Date: _____ / _____ / _____