MARSHALL CLINICAL & FORENSIC PSYCHOLOGY, LLC

INFORMED CONSENT FOR REUNIFICATION THERAPY

PARENT-CHILD REUNIFICATION THERAPY POLICIES, PROCEDURES AND PATIENT CONSENT

Parent-child Reunification Therapy

Reunification therapy is to restore a relationship between a parent and child/children who are estranged and/or not participating in scheduled parent-time. It is not a health care service; it is not treating a diagnosable condition, and cannot be billed to health care insurance. The purpose of reunification therapy is to discuss and resolve the conflicts or disputes that underlie the estrangement so that regular visits and a healthy parent-child relationship can be restored. Reunification therapy can have benefits and risks. Estrangement is a strategy of avoidance, and reunification requires resolving problems without avoidance. It requires meetings where conflicts are discussed, and can be uncomfortable, and anxiety may present in one or more participants to the therapy. Anxiety is not necessarily a reason to terminate services or delay sessions or cancel sessions. The consequences of allowing parental estrangement to persist are well documented in research and include a loss of family and emotional support, loss of financial support, and the development of relationship skills that are associated with poor adult relationship functioning. Successful parent-child reunification restores the severed relationship and relieves the problems associated with estrangement. Services for reunification are offered after it is determined that estrangement exists and parties are referred typically through court order or consent order.

Meetings

- I typically begin by collecting background information about the estrangement. I do this by meeting separately with the estranged parent, the other parent, and the estranged child/children. Then, visits are scheduled for me to meet with the child/children and the estranged parent together as deemed clinically appropriate. These meetings will occur as deemed clinically appropriate with the primary goal of parent-time restored and all parties are satisfied with the quality of the shared time.
- Once an appointment is scheduled, you will be expected to pay for it unless you provide at least 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. If the non-estranged parent cancels the meetings for the children with less than 24 hours-notice the non-estranged parent is typically responsible for the late cancelation fee.

Contacting me

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail where you can leave a confidential message. If you are difficult to reach, please inform me of sometimes when you will be available. In the event of an emergency, call 911. **Do not leave a voicemail in an emergency. I may not receive the voicemail until much later.**

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Email communication is a convenient means for scheduling appointments and exchanging other information. It must be stated that email is not secure as messages are stored on remote servers. Please use caution and consider the non-secure aspect of email when choosing to communicate with me in that format. You may wish to use encryption when sending emails should they contain sensitive information.

Confidentiality

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about the services received to others if you sign a written authorization form. The records are in the name of the estranged parent and the estranged child/children.

There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:
It is often necessary to talk to the non-estranged parent and engage the non-estranged parent in sessions over the course of reunification therapy. Both parents' agreement for such contact is required for participating in reunification therapy, and understood by your consent below. If attorneys or the court are involved, I will need to communicate with them, at my discretion. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation. The other professionals are also legally bound to keep the information confidential.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others to include, but not limited to the police or other emergency personnel who can help provide protection.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are uncommon in my practice.

Child Abuse: If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, emotional abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

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Abuse of Vulnerable Adult: If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.

Harm to others: If a client communicates an actual threat of physical violence against an identifiable victim or victims, I am required to take protective and preventative actions. These actions may include but are not limited to notifying the potential victim and contacting the police, and/or seeking hospitalization for the client.

Communicable Disease: If I have reason to believe that you are suspected of having or are suffering from a disease that is communicable, I am required by law to report this to the local health department.

Minors and Parents

Reunification therapy involves minor children. Consent for their participation is given by the parent, and it is understood that they often would not consent to participate if they were asked. It is common in court- involved cases for the non-estranged parent to be required to see that the minor children attend scheduled meetings.

Professional Fees

My fee in a reunification case is $250 per 75-minute session. In addition to appointments, I charge $200 per hour at a prorated amount (increments of 15 minutes) for other professional services that may be needed. Other services could include letter or report writing, telephone conversations with a party or on behalf of the case, consulting with other involved professionals, preparation of records or summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, the party that issues a subpoena is responsible for my fees. That party agrees to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. For legal involvement, I charge $200 per hour for court/deposition preparation and $400 per hour for my attendance at any legal proceeding, payment is due with the request to appear.

Insurance Reimbursement

Reunification is not a health care service as it’s not considered medically necessary and I won't bill these services to a health care plan nor accept a health care plan’s allowable fees. I also do not participate with any health insurance network.

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Billing and Payments

I require payment at the time of service. I accept cash, check, MasterCard, Visa and American Express. **I require a credit card on file to guarantee payment.** The credit card of the financially responsible party will be charged for amounts not paid at the time of service. If both parents are splitting the costs, I will need a credit card authorization on file for each party. If a payment is not made or a credit card charge is declined, I may suspend my services. I will accept payment on behalf of a delinquent party from any source (including the other parent) to continue services. I will account for the source of payments but will not collect payments for a delinquent party if payment is made by another party.

My fees change infrequently, usually every few years, and by a small percentage. When fees change, they will change on your account. You will receive written notification in advance of any changes in fees.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, this signed contract, and a statement of charges and payments. If such legal action or collections agency is necessary, you will be charged a collection fee of up to 50%, plus any attorney's fees, court costs, and filing fees. You will be charged interest of 1.5% per month on any balance over 30 days that is owed. You will be assessed a $15 statement fee for any month with no billable activity and an unpaid balance. You will be charged my bank fee plus $10 (currently $45) for checks returned unpaid by your bank. Scheduled appointments not cancelled at least 24 hour in advance will be charged to you (full fee at Dr. Marshall's discretion). Any refunds on funds paid via credit cards will have the credit card fees deducted from the refunded amount (currently 2%).

I have read and understand the procedures for emergencies, confidentiality, billing, payment, and I consent to treatment for myself and child(ren) under the conditions described. I agree to the above described terms regarding interest, collections charges, charges for appointments missed or cancelled late, fees for checks returned unpaid, and payment of costs of collecting delinquent accounts.

I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY ITS TERMS.

Do you want us to bill your credit card periodically for the amount you owe? This is the best way to keep your case progressing, as I have to stop working on your case from when I send statements until I receive payment. If you check this option I will send you an itemized statement.

Do you want to receive statements by email? _____Yes _____ No

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_____
Client Signature Date

_____
Legal Guardian Date

(if client is a minor) _____ _____

Financially Responsible Party Date
(if different)
_____

ESTRANGED PARENT
Name:_____
Address:
_____
_____ City: _____ State: _____ Zip Code:
_____ Phone: Home _____ Work:
_____ Mobile: _____ Email:_____ Sex:(M : F) Date of Birth:
_____ Age: _____

NON-ESTRANGED Parent

Name:_____
Address:
_____
_____ City: _____ State: _____ Zip Code:
_____ Phone: Home _____ Work:
_____ Mobile: _____ Email:_____ Sex:(M : F) Date of Birth:
_____ Age: _____

ESTRANGED CHILD 1 Name:
_____
Address:_____
_____ City: _____ State: _____ Zip

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INFORMED CONSENT FOR REUNIFICATION THERAPY

Code:_____ Phone: Home _____ Work: _____ Mobile: _____ Email:_____ Sex:(M : F) Date of Birth: _____ Age: _____

ESTRANGED CHILD 2 Name:

_____

Address:_____

_____ City: _____ State: _____ Zip Code: _____ Phone: Home _____ Work: _____ Mobile: _____ Email:_____ Sex:(M : F) Date of Birth: _____ Age: _____

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RESPONSIBLE PARTY IF DIFFERENT THAN ESTRANGED Parent (Statements will be sent to)
This must be the person signing fee agreement as responsible party Name:
_____
_____ Address:
_____
_____ City: _____ State: _____ Zip Code:
_____ Phone: Home _____ Work: _____ Mobile:
_____ Email:_____