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Beljan Psychological Services

9835 E. Bell Rd., Ste. 140
Scottsdale, AZ 85260
(602) 957-7600
www.beljanpsych.com

Informed Consent in Cases of Divorce/ Shared Custody

In cases of shared custody please look over this form carefully before signing. If we do not have this document signed by both parents at the time of service we will not be able to see your child for therapy, gifted testing, psycho-educational testing, or neuropsychological evaluations. In cases of sole custody please bring a copy of the decree/legal documentation for our records.

Divorce, Custody, or Legal Issues

As a mental health practice our primary focus, responsibility, and goal is the treatment and well-being of our identified patients. In the case of a child as the primary patient it is essential that parents and legal guardians who are not in conflict and are in fact in agreement as to the decision to treat, the treatment goals, appointment times, need to maintain patient confidentiality. The therapeutic process and assessment are a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means that you each agree as a condition of treating your child, assessing your child's emotions, or performing a neuropsychological evaluation, that:

- You shall treat anything that is said in any individual or group therapy session as strictly confidential;
- Our role is limited to providing treatment, assessing emotions, and/or performing a neuropsychological evaluation on your child and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;
- You shall not request or require us, through subpoena, summons, or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the other in any legal proceedings relating to the care and custody of your child; and
- If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more Authorization to Release Information forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinicians time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure or treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements. We do not specialize in cases of custody.

For families of divorce and/or ongoing child custody issues, Beljan Psychological has the following policy:

- Any email sent to Beljan Psychological Services is to be contemporaneously sent (cc'd) to the other parent(s) and any other attorney, child custody evaluator, mediator, or judge who is a party involved in the ongoing issue. Parents must sign appropriate Release of Information forms, provided by Beljan psychological Services, to initiate this process.

- Beljan Psychological Services reserves the right to close your case and you will be provided three appropriate referral sources for your failure to comply with this policy.

- If any parent/guardian wishes to have Beljan Psychological Services stop services at any given time the request needs to be made directly to Beljan Psychological Services and not to another parent/guardian. _____**(Initials).**

In cases one parent is not able to be present at an appointment I accept the responsibility of communicating with them after every appointment to be updated regarding any change in the treatment plan related to my child's assessment and/or treatment.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my child under these terms and conditions set forth above by signing below.

_____ _____
Printed Name Date

_____
Signature

_____ _____
Printed Name Date

_____
Signature

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IN CASES OF SHARED CUSTODY & SHARED/SOLE FINANCIAL RESPONSIBILITY

I understand that I am responsible for any and all payments due in accordance to the information provided below. For any party responsible for payment a credit card authorization is required for each. Any payments received will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, Beljan Psychological Services will take appropriate action. You will be expected to pay for each session at the time it is held. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we reserve the right to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, all costs will be included in the claim and be the responsibility of the patient.

I _____am responsible for _____% of services rendered

_____ _____
Printed Name Date

_____ _____
Relationship to Child Signature

I _____am responsible for _____% of services rendered

_____ _____
Printed Name Date

_____ _____
Relationship to Child Signature

_____ _____
Administration/Clinician Name Date

_____
Signature