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INFORMED CONSENT FOR REUNIFICATION THERAPY
OR CO-PARENT COUNSELING

I, the undersigned, understand that the services referred to in this document are oriented toward the welfare of the child(ren) identified as the focus of these services, and not necessarily to my personal goals. I understand that radical changes in my communication with and reactions toward my co-parent (your child's other parent) are likely to be required to meet my child's emotional needs for a mutually respectful, cooperative, and functional relationship between his or her co-parents. I understand that my child's present and future mental health are at risk if his or her parents cannot provide him or her with such a co-parenting relationship.

I understand that it will require the signatures of all adults involved in Reunification Therapy or Co-parent Counseling in order for Dr. Byrd to release the associated therapy records to another health service provider, legal representative, or other professional, in part or in whole. However, no signatures are required to release information or to testify in the case of a subpoena or court order.

I understand that information discussed in Reunification Therapy or Co-Parent Counseling is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. However, if my therapy is taking place alongside or as part of court proceedings, if I have an attorney advising me in matters related to the services I am receiving, or if my co-parent is receiving advice from an attorney on those matters, Dr. Byrd will from time to time update the attorney(s) on therapeutic progress and level of cooperation from the participants in therapy. I will also receive a copy of these updates.

I understand that these same updates will be provided to 1) other therapists involved with you or the children who are receiving services from this office, 2) the Guardian ad Litem and/or the Parenting Coordinator if either of these parties are involved with my family system.

I understand that aside from the communications delineated above, my records will be held with the same level of confidentiality and privacy as any other mental health records. However, there are exceptions to those regulations as well, specifically:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.
7. If we see each other accidentally outside of the therapy office, I will not acknowledge you first. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but it is appropriate not to engage in any lengthy discussions outside of the therapy office.

I further understand that if, during the course of therapy, one co-parent threatens physical or emotional harm toward the other co-parent or the child, or one co-parent alleges such threats or actions from the other co-parent, the services of this office will be interrupted and the attorneys will be notified. Additionally, I understand that if there is a Child Services investigation of alleged child abuse involving this family system, services will not begin or continue until the investigation is complete.

I understand that while working in Reunification Therapy or Co-Parent Counseling I am to cc any written correspondence with Dr. Byrd, including email, to my co-parent. There will be no back-channeled (1:1) communication between Dr. Byrd and either partner, outside of the intake assessment and some individual appointments at the therapist's discretion. I understand that anything I or my co-parent might say to Dr. Byrd individually, whether by digital media, phone, or in an individual session, may, at Dr. Byrd's discretion, be shared with the co-parent during a subsequent session.

I am aware that it is important that sessions occur at least weekly, and that if a session is missed every effort will be made to complete two sessions the following week.

I agree to share responsibility with Dr. Byrd and my co-parent for the therapy process, including goal setting and termination. By entering into therapy, I understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapeutic goals on behalf of the child(ren).

I have read and understood all of the information under "Reunification Therapy and Co-Parent Counseling" including the pages, "Before Our First Meeting" and "Guidelines and Procedures" at the website, carmelpsychology.com. I understand that the paperwork described on the "Before Our First Meeting" must be received at my office before our first meeting.

I understand that the fee for 50-minute visits is $150, and that *the fee must be paid at the time of service*. Customarily, for Reunification Therapy services the involved child will be the identified patient for insurance purposes. For Co-Parent Counseling, the identified patient for insurance purposes will be determined at the first meeting involving both co-parents. I understand that Dr. Byrd is not an enrolled provider with any insurance company and he does not submit claims to insurance companies. However, he will provide me with a statement that most insurance companies will accept as a claim for out-of-network reimbursement.

_____	_____	_____
Signature	Printed name	Date