Slater & Associates, LLC

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Parenting Coordination Contract

PRINCIPLES

1. The parents acknowledge that their child(ren) will benefit from a meaningful relationship with both parents, that parental conflict will negatively impact their child(ren)'s adjustment, and that every effort should be made to keep the child(ren) out of the parents' disputes.

2. We understand that it is in the child(ren)'s best interest when parents do not engage in conflict. To that end, we will attempt to resolve our issues in a mutually satisfactory manner between ourselves whenever possible. If issues cannot be resolved between us, either one of us may request the assistance of the Parenting Coordinator (PC) who shall engage in a process to help us resolve disputes.

ROLE AND OBJECTIVE OF THE PARENTING COORDINATOR

1. The role of the PC is to assist both of you in resolving conflicts in a manner that is beneficial to your child(ren). What is in the best interest of your child(ren) will remain the primary focus. You may have enlisted these services voluntarily or may have had such services stipulated by the court. Regardless, it is understood that your PC cannot change the legal custody status of the child(ren).

2. The PC may provide individual consultation, coaching or education to the parents, at the discretion of the PC.

3. The PC may speak to the child(ren) and may contact third parties, including but not limited to therapists, teachers, coaches, doctors, other medical care providers, caregivers, employers or attorneys and to review any relevant documents.

4. The PCs at Bluegrass Family Therapy have knowledge and experience in the areas of child development, family systems theory and dynamics, the effects of separation/divorce on child(ren), adolescents, and adults, high conflict families, and psychological functioning, from which the parents may benefit. Notwithstanding, the PC is not functioning as a psychotherapist, marriage and family therapist or clinical social worker for either of us, our family, or our child(ren).

5. The parents understand that the PC is not a lawyer and will not be providing legal advice.

THE PARENTING COORDINATION PROCESS

1. The parents agree to utilize the PC to assist them in resolving conflicts that may arise from the implementation of their court orders/parenting plan in a manner consistent with the child(ren)'s best interest and that attempts to minimize parental conflict.
2. Throughout the course of serving as your PC, a parenting coordination agreement (PC Agreement) will be created and maintained which describes the progress and any agreements the parents have made. Copies of all PC

Agreements and reports will be forwarded to both parents and to your respective attorneys (unless otherwise requested), and to the judge, if required.

3. This Contract cannot cover all the particulars that may arise in every situation. **The parents agree that the PC may need to establish new rules and guidelines to fit the parents' unique relationship.** The fundamental principles governing all rules and guidelines are (a) conflict for the parties will be minimized and (b) recommendations will be made in the best interest of the child(ren).

4. Appointments with the PC may be scheduled at the request of either parent or of the PC. All parties agree to make a good faith effort to be available when an appointment has been requested.

5. Whether appointments will be held jointly or individually will be at the discretion of the PC. It is understood that sessions where both parents are present are the norm, except in cases whereby direct contact is prohibited by court order.

6. The parents understand that any threat of harm toward the other parent, direct or implied, will result in the immediate termination of PC services and will be reported to the court when appropriate. Additionally, any threat, implied or otherwise, directed at the PC, will also result in immediate termination of PC services and will be reported to the court as such.

7. If the PC deems him/herself no longer able to work with either parent in a productive manner, the PC shall provide each parent with five (5) days written notice and shall notify the court and counsel in writing and request that the appointment be terminated. In that event, the PC may suggest the names of other potential parenting coordinators to the parents.

8. The PC's services may be terminated by agreement, provided, however, it shall be the responsibility of the parents to have a court vacate the appointment (if court-ordered) prior to termination of services. If one parent wishes to terminate the services of the PC and the other parent does not agree, an order of the court is required to vacate the appointment.

9. Parenting Coordination is not a crisis service. Therefore, you will be expected to schedule appointments in advance. Appointments will be held during regular business hours.

10. Agreements reached by the parents shall be drafted by the PC and provided to clients and attorneys. Agreements reached in session will be implemented from that date moving forward. No changes to, or retraction of, agreements reached will be permitted once the session has ended.

CONFIDENTIALITY

1. Parenting coordination is NOT a confidential process. The PC will initially meet separately with each parent for the purpose of, among other things, screening the parents for the suitability of the process, including but not limited to, violence and power imbalances.

2. All previous or current therapists for the parents and/or child(ren), attorneys, judges, and/or previous or current evaluators are authorized to exchange information with the PC. Any other professionals that work with the child(ren) or parents are authorized to exchange information with the PC, including but not limited to, current employers, schoolteachers, coaches, physicians, other medical providers, and other family members. The PC may disclose to the parents all or any part of any information received from third parties, the other parent, and the child(ren). The parents agree to promptly complete, sign and return any and all releases for information that third parties may require to exchange information with the PC.

GRIEVANCES

1. Either parent who has a grievance regarding the way the PC is dealing with him/her or any issue, he/she shall discuss their concern in person with the PC before pursuing it in any other manner. If, after discussion, the parent is not satisfied that the grievance has been dealt with satisfactorily, then he/she shall submit a written letter detailing the grievance to the PC, to the other parent and to any lawyers representing the parents and/or child(ren). The PC shall provide a written response to the parents and lawyers within twenty (30) days.

2. The PC shall then meet with parents and attorneys to further discuss the matter.

3. If the grievance is not resolved after this meeting, the complaining party may file a motion with the court to vacate the PC's appointment. The court shall determine if the PC should be replaced or if the parties shall continue with the current provider.

FEE ARRANGEMENT

1. Scheduled parenting coordination appointments may NOT be canceled or rescheduled by a parent except in the most extreme circumstances or by mutual consent of the parents. The parent who cancels or reschedules a session will be responsible for the full session fee, as well as all charges incurred in the handling of the cancellation or rescheduling, including but not limited to time expended for phone calls and emails to and/or from the other parent and for communication with attorneys and/or the judge.

2. We agree to pay the PC at the rate of $250 an hour, with the PC reserving the right to assess costs disproportionately, unless otherwise specified by court order.

3. The Slater & Associates, LLC Fee Agreement is incorporated herein by this reference.

SIGNATURES

Both parents:

- Have read or had the opportunity to read this Contract in full in the presence of the PC;
- Consent to all of the above terms of service; and
- Acknowledge that this Contract is a legally binding agreement.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Signature	Printed Name	Date

_____	_____
Parenting Coordinator	Date

Slater & Associates, LLC

Parenting Coordination Intake Form

Your Name: _____Your DOB: _____Age:_____
First Middle Last

Former Spouse's Name: _____ DOB: _____Age:_____
First Middle Last

Address: _____ City: _____ Zip:_____

E-Mail Address: _____

Occupation: _____ Employer:_____

Education Level (circle one): HS Bachelor Master Doctorate

Number of Marriages: _____ Your Gender (circle one): M F

Relationship Status (check one) ____Single _____ Married _____ Divorced ____Committed Relationship

Home Phone: _____ OK to leave message? Y N
Cell Phone: _____ OK to leave message? Y N

Legal Information:

Attorney's Names:

Mother's Attorney: _____ Phone: _____

Father's Attorney: _____ Phone: _____

County of Divorce: _____

Date of Divorce: _____

Judge: _____

Current Custody (circle one): Joint Sole Split

Current Timesharing Arrangement:
Mother: **Father:**

Please list below all children from this or previous marriages/relationships. (include biological, adopted & step children living in your household or not)

Name	Age	Gender	Relationship	School _____	Grade	Type of Custody?
_____	____	_____	_____	_____	_____	□ Joint □ Sole
_____	____	_____	_____	_____	_____	□ Joint □ Sole
_____	____	_____	_____	_____	_____	□ Joint □ Sole
_____	____	_____	_____	_____	_____	□ Joint □ Sole
_____	____	_____	_____	_____	_____	□ Joint □ Sole
_____	____	_____	_____	_____	_____	□ Joint □ Sole

Who currently lives in your home?

Name	Age	Gender	Relationship
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Who referred you?

_____	Doctor / Psychiatrist	_____	Mental Health Professional
_____	School	_____	Court
_____	Friend	_____	Employer
_____	Internet	_____	Attorney
			Name: _____

Medical History (Self):

Current Health Problem	Treating Physician	Medication

Have you ever been diagnosed or treated for a mental illness or personality disorder?

Names of any current or past mental health providers:

Briefly describe the co-parenting issues you would like to resolve in Parenting Coordination:

Slater & Associates, LLC

Authorization to Disclose Health and Educational Information

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

I authorize the use or disclosure of the above-named individual's educational and/or health information as described below for use by Slater & Associates, LLC to assist in the diagnosis and treatment of the named individual and/or the individual's family. I also authorize Slater & Associates, LLC to communicate relevant information obtained over the course of treatment/consultation to the individual, entity, institution and/or schools listed below.

Name of the individuals, entities, institutions and/or schools authorized to make the disclosure:

1._____
2._____
3._____
4._____
5._____
6._____

The type and amount of information to be used or disclosed is as follows:

- □ All special education records
- □ All school records (including attendance, faculty observations, anecdotal and/or counseling notes, and discipline records)
- □ All medical records
- □ All diagnostic and assessment information including psychological or psychiatric reports and evaluations
- □ Results of Drug & Alcohol Testing
- □ Laboratory results
- □ All records as needed for assessment, treatment planning and coordination of services or other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Slater & Associates, LLC. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Signature of Client or Legal Representative Date

Slater & Associates, LLC

Release for Audio/Video Recording

I hereby authorize Bluegrass Family Therapy, LLC (BGFT) to audio and/or video record the assessment and/or therapy services rendered to me and/or my child/ren. I understand that the use of audio or video taping may be used for clinical review and/or training purposes. I therefore consent to the use of AV equipment during treatment sessions. The recording will not be released to any external entity without my explicit written permission unless subpoenaed by a court of law. Recordings may be destroyed following clinical review.

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Slater & Associates, LLC

Fee Agreement

- I understand that I will be responsible for full payment of the session fee, as well as for any outstanding balance, prior to my scheduled session. Face-to-face appointments, as well as telehealth calls, lasting longer than 5 minutes, will be billed at the same hourly rate. The initial hourly rate shall be $_____.

- If two or more parties will be responsible for services, Slater & Associates, LLC may charge either party the full fee, or at our discretion, the fee may be charged disproportionately.

- All time involved in the preparation of written reports, telephone calls, communication with other professionals and travel will be billed at the same hourly rate.

- I understand that I will be responsible for any postage (first class postage rate) or copying fees ($1.00/page) incurred on my behalf by Slater & Associates, LLC.

- Any time set aside in preparation for a subpoenaed court appearance, including actual appearances, preparation of testimony or reports to your attorney or the court, travel, depositions, or any schedule adjustments necessary to accommodate such a court appearance will be billed at an hourly rate of $300/ hour. Slater & Associates, LLC will charge a retainer in advance of any agreed or subpoenaed court proceeding in a minimum amount of $2,500 (or such time estimated to be expended). This retainer shall be a deposit towards fees for professional time expended. If time expended is less than the retainer, the balance will be refunded within 30 days of termination of services. If time extended exceeds the retainer, the balance will be charged to the account/s on file.

- **I agree to notify Slater & Associates, LLC at least 48 hours in advance should I need to cancel an appointment. I understand that I will be charged <u>the full regular session fee</u> for any appointments that I miss or fail to cancel 48 hours in advance.**

- I agree to pay any Slater & Associates, LLC costs of collection including reasonable attorney fees.

- I understand that I will need to provide a valid credit card that will remain on file with Slater & Associates, LLC, and I authorize Slater & Associates, LLC to keep my signature on file for charges incurred on my account.

Name on card: _____
Credit Card (1) Number: _____
Expiration: _____
3-digit security code: _____
Billing zip code: _____

Cardholder signature: _____

Name on card: _____
Credit Card (2) Number: _____
Expiration: _____
3-digit security code: _____
Billing zip code: _____

Cardholder signature: _____

I have read the information above and agree to the terms set forth and outlined above.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date