PLEASE SIGN AND DATE BELOW TO ACKNOWLEDGE RECEIPT OF THIS IMPORTANT INFORMATION

All court and disability clients are required to pay a $1,000.00 prior to services rendered.

Prior to your first appointment, please print out and complete all intake forms and bring with you to your appointment. We strongly urge you to keep a copy of your paperwork for your files.

We currently accept check or cash only for sessions, if you choose to pay cash or check for your session please do so at the beginning of your session, otherwise the session costs will be deducted from your retainer.

Please contact us with 24 hours notice if you need to cancel/reschedule your appointment to avoid the late/no cancel fee of $150.00 as noted in our financial policy. Cancellation of sessions without 24 hours notice are the financial responsibility of the party that cancelled unless otherwise agreed to in writing.

_____

Print Name

_____

Signature

_____

Date

Karen Wood, LMHC, CAP
2400 North University Drive Suite 201
Pembroke Pines, Florida 33024
Phone (954)529-0885
www.BrowardCounseling.com

COURT ORDERED - DISABIILTY CLIENT STATEMENT OF UNDERSTANDING

1. **Court Order - Disability Compliance**
   Court ordered - disability clients are required to comply with certain guidelines to ensure to best possible outcome in services. We require that clients attend a minimum of every two weeks unless otherwise advised by the therapist or the courts. Court Ordered Parents are expected to coordinate their own schedules. Therapist and office manager are not to be used to communicate between the parents for scheduling purposes. YOU WILL BE BILLED FOR EMAILS AND PHONE CALLS RELATED TO APPOINTMENT SETTING RESULTING FROM FAILURE TO COMMUNICATE BETWEEN PARENTS. Repeated scheduling difficulties could result in your case being sent back to the judge for noncompliance.

2. **Reunification Boundaries**
   It is our policy to request that the non-reunifying parent please not be in the waiting room during sessions unless specifically requested by the therapist. This allows the child to focus fully on the session and not feel uncomfortable regarding the possibility of conflict between parents during pick up and drop off. If there is an issue, the therapist will call you or bring the child to come find you on the property. The child will be in the presence of the therapist at all times with the exception of semi-supervised visitations during which time the therapist will be in a connecting room at all times. It is also very important in most cases for both parents to participate in the process in some form. Compliance with therapist recommendations by both parents is mandatory and essential to the best interest of the child(ren).

3. **Billing**
   Please be advised that all court or disability involved cases require a retainer of $1,000.00 (unless other arrangements are approved by the therapist). Retainers may be paid by check, cash or credit card. Please note if you choose to use a credit card a fee of $25.00 will be charged to you in addition to the $1,000.00 retainer. At the end of the treatment any retainer balance will be returned to the client. Retainer amounts must be kept at a minimum of $300.00. If your retainer balance falls below $300.00 and it is 48 hours prior to your next scheduled session, that session will be cancelled until the retainer amount is replenished to $1,000.00; replenishing your retainer is necessary regardless of the clients' intent to pay cash or check for that session. The client will be provided with an itemized statement monthly or at the time your retainer falls below $300.00. At this time the client will be required to replenish their retainer to $1,000.00. All services will be suspended until the retainer is replenished.

4. **Services**

   Clients involved in legal proceedings, reunification, co-parenting or Parent Coordination will be charged for all phone calls, emails, texts, report writing/review at a rate of $150.00 per hour charged at one-tenth of an hour. Disability clients will be charged for all paperwork, phone calls, emails, texts, report writing/review at a rate of $150.00 per hour charged at one-tenth of an hour. These services are NOT covered by your insurance plan. Court preparation, travel and appearance are charged at $200.00 per hour and a minimum of two weeks' notice is required.

5. **Court Appearances**

   All subpoenas for court appearance or deposition must be made with a minimum of two week's notice. No depositions shall occur in the therapist's office as it does not accommodate enough people. A minimum of two hours preparation time must be agreed to, a minimum of three hours appearance time must be agreed to and a minimum of 90 minutes of travel must be agreed to and paid for prior to the therapist agreeing to appear. The total minimum for this is $1,300.00 due at least two weeks in advance. All fees are due in advance. These services are NOT covered by your insurance plan.

6. **Cancellation of sessions without 24 hours notice are the financial responsibility of the party that cancelled unless otherwise agreed to in writing and are billed at $150.00 per session.**

   This agreement MUST be signed by all attorneys and clients prior to beginning any services.

Client _____Date_____

Client_____ Date_____

Attorney_____ Date_____

Attorney_____ Date_____

Deposition/Expert Witness Retainer Agreement for Karen Wood, LMHC, CAP

Case Name: _____ Name:_____

Please initial either "yes" or "no" below

_____YES
_____ NO

The entity requesting this deposition, any of the entity's business associates, or any associated clients have named Karen Wood, LMHC, CAP as a defendant in this matter, may name Karen Wood, LMHC, CAP as a defendant in this matter, or may use the material discussed in the deposition to substantiate a claim against Karen Wood, LMHC, CAP.

The party requesting this deposition agrees to the following terms prior to confirmation of this deposition.

Deposition and/or court testimony, preparation and travel time $200/hour calculated in 10 minute increments

1. The deposition/appearance being requested is made based upon Karen Wood, LMHC's professional capacity as a psychotherapist, Karen Wood, LMHC, CAP is therefore entitled to the fees stated above as opposed to standard witness fees.
2. Karen Wood, LMHC, CAP's schedule is made far in advance and last-minute changes are often disruptive to both scheduling and patient care. Therefore, unless otherwise agreed in writing, depositions/appearance will be scheduled and pre-paid with at least 14 days advance notice.
3. In the event that a deposition/appearance must be canceled, notice will be provided as soon as possible via **phone at 954-529-0885 *and* via e-mail at karen.wood@browardcounseling.com.** Preparation time is non-refundable. Travel and appearance fees are refundable with one week notice minimum. Notice will be confirmed upon receipt.
4. If a scheduled deposition/hearing is canceled more than once, the entity requesting the deposition agrees to pay a non-refundable fee of **$350** as compensation for time that must be spent re-scheduling future depositions and lost wages.
5. Reimbursement for time testifying at the deposition/appearance will be made regardless of the outcome of the case and regardless of the material that is discussed during the deposition.
6. Time spent testifying at deposition/appearance does not include time spent reviewing medical records to prepare for the deposition. Arrangements to review medical records prior to scheduling a deposition must be made in advance and time spent reviewing medical records will be paid at the above rates. Preparation of a minimum of two hours is mandatory.
7. Travel time to and from designated place of deposition or court hearing will be included in total time charged and will be paid at above rate. Travel time of a minimum of one and one half hours is mandatory.
8. Depositions/Appearances shall not be scheduled in Karen Wood's office as it does not accommodate for this activity.

By signing below, the attorney requesting this deposition/appearance agrees with the above terms and personally guarantees to reimburse Karen Wood, LMHC, CAP for above-stated fees and to reimburse Karen Wood, LMHC, CAP for all costs associated with collection of unpaid deposition fees and/or breach of this agreement. A minimum of 50% must be paid at least one week prior to the date of deposition/ court hearing or this agreement is null and void.

_____

Signature of Attorney Requesting Deposition /appearance ***Print Name and Date***

_____

Signature of Client Requesting Deposition /appearance ***Print Name and Date***

Date:_____

Case Name:_____

Estimated time needed:_____

Chart/report review: _____

Travel time to and from Pembroke Pines to _____: ____hours

Estimated time in chambers/waiting: ____ hours

Total estimate: ____ hours

Total estimated fees: $_____

Please return by fax as soon as possible to 954-450 -0114 or email at karen.wood@browardcounseling.com

Thank you.

INTAKE (MOTHER/FATHER)

Client Information:

Name_____ Home Telephone_____

Address_____ Work Telephone_____

_____ Cellular Telephone_____

Email_____

Best Time and Place to call you:_____

Attorney information:

Name_____ Telephone_____

Address_____

_____ Fax Number_____

Email: _____

Judge:_____

Child Name:_____ Birth Date:_____ School:_____

Child Name:_____ Birth Date:_____ School:_____

Child Name:_____ Birth Date:_____ School:_____

RELEASE OF INFORMATION FORM

As part of the court's appointment of a parenting coordinator, co-parenting therapist or reunification therapist, the therapist may have contact with any individual or professional party they deem necessary to effectively work with our family. I understand that this is not a confidential process. However, information will not be shared with anyone outside the family's involvement or outside the process we are working on. Therefore, I grant the therapist the right to add names to this form after my signature as long as they inform me about this addition prior to making contact.

I understand that this release is in effect until the court removes us from the program or we are assigned to another therapist. In the situation of a transfer to another therapist, I give the current therapist permission to release and/or copy all our records to the next professional and to bill us up to one hour for a consultation with the new professional.

Attorney _____ (____)_____

Guardian ad Litem _____ (____)_____

Custody Evaluator _____ (____)_____

Psychotherapist _____ (____)_____

Psychotherapist _____ (____)_____

Child's Psychotherapist _____ (____)_____

Child's Teacher/School _____ (____)_____

Previous Parenting Coordinator_____ (____)_____

Other _____ (____)_____

Other _____ (____)_____

Other _____ (____)_____

Other _____ (____)_____

Other _____ (____)_____

Only when ordered or subpoenaed:

Honorable Judge _____ (____)_____

_____ _____

Parent Name - Print Date

_____ _____

Parent Name - Signature Date

Karen Wood, LMHC
2400 North University Drive. Suite 201
Pembroke Pines, FL 33024

Authorization for Recurring Credit Card Charges

Credit card charges will be made under the name Karen Wood, LMHC. All credit card information is filed with your confidential client information and kept secure.

Name of Client_____

Account Type: □Visa □MasterCard □Discover

Cardholder Name: _____

Account Number: _____

Expiration Date: _____ House #: _____ Zip Code: _____

CVV - 3 digit number on the back of your card : _____

I authorize Karen Wood, LMHC to charge this credit card for professional services and associated charges as agreed below. These charges may include:

____(initials) All court involved and disability clients are required to pay a **$1,000.00** retainer .

____(initials) Payment for sessions not covered by insurance: **$150.00** per session

____(initials) Charge for cancellation without 24 hours' notice: **$150.00**

____(initials) Charge for a no-show appointment: **$150.00**

____(initials) Phone sessions, emails, texts and emergency phone calls are billed at the rate of **$150.00** per hour.

____(initials) Court appearance/deposition related services including preparation, travel and appearance **$200.00** per hour

____(initials) Use of a credit card will result in a **$25.00** administrative fee. Cash or check is preferred.

____(initials) I agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, which will be charged for any outstanding balance owed.

____(initials) Outstanding balances beyond 30 days are subject to a **$20.00** administrative fee being added to your account balance EVERY 30 DAYS due to administrative costs. Outstanding balances beyond 60 days are subject to your account being forwarded to an outside collection agency.

____(initials) I agree to not dispute any charges and understand that if I do so I will be responsible not only for the charges for services rendered but any charges accrued by the credit card company. All invoices are charged based on records kept on file and are allowed to be released to all parties in the case of a dispute.

____ (initials) I understand that this authorization will remain in effect until I cancel it in writing or one year from the date of signing.

Signature of Authorized Credit Card Holder:_____ Date:_____

FINANCIAL POLICY FOR INSURANCE CLIENTS

I consent to psychological therapy, consultation and/or testing. I understand that it is my responsibility to cooperate with treatment. Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. **I understand that if I do not agree with this policy I have the option to pay cash for services to protect my privacy.**

Signature: _____ Date: _____

Signature: _____ Date: _____
(Second parent)

I authorize payment of medical benefits to Karen Wood, LMHC for services rendered. If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment of the medical benefits for services rendered in our office. All follow-ups with the insurance company are the responsibility of the patient.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with your therapist. If you have health insurance, it should be understood that this is an arrangement between you and your insurance company to pay you certain amounts for medical care. Your therapist's bill is an agreement between you and your therapist. You are responsible for payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees, which they will pay. Your therapist's fees may be more or less than this actual schedule. You are directly responsible to the therapist for your account, regardless of your insurance company schedule. If you fail to meet your financial responsibilities, your account may be turned over to a collection agency or the appropriate court. You will be responsible for a $20 administration fee per month for every month that our office attempts to collect on any amount owed. I hereby give my consent to release necessary information for taking such action. The patient will be responsible for any fees incurred because of collection or court actions.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Because time has been reserved exclusively for me and/or family member(s), I understand that I am required to provide at least twenty-four (24) hours advance notice if unable to keep the scheduled appointment. **In the event that I do not provide the twenty-four (24) hour notice prior to cancelling, I am responsible for the reserved appointment at the rate of $75.00 for insurance clients and $150.00 for court and disability clients.**

I hereby assume responsibility for all charges that may be incurred for treatment rendered to myself and/or family member(s). I understand the above described financial policy. I have also read and understood the Patient's Rights and responsibilities and the HIPAA Notice of Privacy Practices. I received a copy of both to retain for my records.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

KAREN WOOD, LMHC, CAP
CONSENT FOR SERVICES

As a client of Karen Wood, LMHC, CAP we are obligated to inform you of your rights to confidentiality.

I understand that I am ensured the following rights:

- The right to refuse and /or terminate treatment at any time.
- The right to a complete description and explanation of my counseling.
- The right to confidentiality, whereby, information revealed by me during individual or group therapy , evaluation or testing will be kept STRICTLY CONFIDENTIAL and will not be revealed to anyone without my written authorization. The law provides exceptions to this provision:

1. If the therapist has knowledge of the clients' intent to harm himself or others (homicide/suicide with a plan).
2. If the therapist receives a court order to the contrary.
3. If the therapist has knowledge of neglect/abuse to children or elderly.

Due to grey areas of duty to warn regarding HIV issues, our counselors have chosen to adopt the policy of working with the client regarding these grey area issues. This policy will reduce the risk of jeopardizing the therapeutic relationship and also protect the liability of the therapist to the greatest extent possible regarding invasion of privacy, defamation, or breach of confidentiality. These issues include but are not limited to:

1. If, in my opinion, therapy cannot profitably proceed unless something you tell me is shared with another party. I may need to give you the choice of telling the other party yourself, having me tell them, or terminating therapy.

2. I have an ethical obligation to balance the interests of all human beings. If you tell me, in my opinion, of a situation that may be unethical, harmful, or unfair, I may, at my discretion, give you the choice of correcting the situation if possible, informing relevant party(ies) of the situation, having me tell them, or terminating therapy.

3. In general, I will follow, to the best of my ability, all state laws and regulations, as well as the policy and code of ethics of the Florida Department of Professional Regulation.

4. Please feel free to ask for clarification about any of these matters at any time, either now, during therapy, or before you tell me something I might have to share with others.

Please note that payments are due upon receiving services. We require a 24-hour notice of cancellation of appointments to avoid being charged a missed appointment fee of $75.00 dollars for insurance clients and $150.00 for court and disability clients. Repeated cancellation of appointments and/or failure to comply with treatment recommendations is counterproductive and may result in termination of your treatment with the option of referral to another treatment source.

5. Checks returned for insufficient funds will be subject to a fee of thirty five dollar ($35.00) administration fee above and beyond the bank's penalty fee. If such an event occurs more than once, you will be asked to make payment in cash or money order.

6. Sessions are an average of 45 to 50 minutes in length.

7. If you are finding it difficult to wait until your next session to speak to your therapist you will need to schedule appointments more than once per week. Please remember, telephone calls are for appointment arrangements only, not to have sessions over the phone unless this was previously arranged with your therapist.

8. Emails and texts are also billable and not covered by insurance.

9. In case of an emergency at a time when your therapist is out of town call 911 or First Call For Help at 954-467-6333.

10. **Clients involved in disability filings, legal proceedings, Reunification, Extended Co-Parenting or Parenting Coordination will be charged for all phone calls, emails, texts, report writing/review at a rate of one hundred and fifty dollars ($150.00) per hour and court appearances/depositions door to door at a rate of two hundred dollars per hour ($200) charged at one-tenth of an hour including preparation time and travel. These services are NOT covered by your insurance plan. IF YOU BECOME INVOLVED IN A FAMILY COURT CASE AT ANY TIME DURING YOUR TREATMENT, YOU MAY BE SUBJECT TO THIS GUIDELINE.**

11. **Please be advised that all court and disability involved cases require a retainer of $1,000.00 (unless other arrangements are approved by the therapist). Retainers may be paid by check, cash or credit card. Please note if you choose to use a credit card a fee of $25.00 will be charged to you in addition to the $1,000.00 retainer. At the end of the treatment any retainer balance will be returned to the client. Retainer amounts must be kept at a minimum of $300.00. If your retainer balance falls below $300.00 and it is 48 hours prior to your next scheduled session, that session will be cancelled until the retainer amount is replenished to $1,000.00; replenishing your retainer is necessary regardless of the clients' intent to pay cash or check for that session. The client will be provided with an itemized statement monthly or at the time your retainer falls below $300.00. At this time the client will be required to replenish their retainer to $1,000.00. All services will be suspended until the retainer is replenished.**

12. **All clients involved in parent/child reunification counseling must respect the process by following all recommendations of the therapist. The non-participating parent may not be present in the waiting room during the time of the reunification session and may not attend these sessions unless it is requested by the therapist. Any information non-participating parent feels it is necessary to share will occur via a separate appointment. This time is not billable by your insurance company.**

I hereby certify that I understand the above and have been informed of service policies and procedures. Furthermore, I authorize Karen Wood, LMHC, CAP to render necessary treatment and to file appropriate insurance claims for this treatment if necessary. If I do not have insurance, I agree to pay for services as they are rendered.

Name _____ Date _____