

OFFICE OF KAREN WOOD, LMHC

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

ATTENTION: THIS PACKET MUST BE INITIALED ON EACH PAGE, SIGNED AND DATED IN THE APPROPRIATE AREAS THEN RETURNED TO OUR OFFICE IN ITS ENTIRETY (11 PAGES).

All court and disability clients are required to pay a \$2,000.00 retainer prior to services rendered.

This retainer must be replenished at any time it goes under \$300.

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 48 hours notice if you need to cancel/reschedule your appointment to avoid the late/no cancel fee of \$175.00 as noted in our financial policy. Cancellation of sessions without 48 hours notice are the financial responsibility of the party that cancelled unless otherwise agreed to in writing.

Print Name

Signature

Date

Initials_____



Karen Wood, LMHC, CAP

COURT ORDERED STATEMENT OF UNDERSTANDING

1. **Court Order Compliance**

Court ordered clients are required to comply with certain guidelines to ensure the 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 assistant 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. If communication between parents is an issue, it is strongly recommended that the parents make an appointment to discuss how they can come to an agreement regarding scheduling. Our Family Wizard is highly recommended.

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. Many children also are unable to focus during sessions with the parent in the waiting room for fear that the parent can hear the conversation. Please respect this process although it may at times feel uncomfortable. We then request that the parent that is transporting the child home return 45 minutes later and wait in the hallway. 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) unless otherwise ordered by the judge. Any parent that does not return on time will be assured that the other parent will be removed from the premises and the children will be put in a safe room, however the parent that is late will be responsible for any late fees.

3. **Billing**

Please be advised that all court involved cases require a retainer of \$2,000.00 (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 4% will be charged to you in addition to the \$2,000.00 retainer. At the end of the treatment any retainer balance will be returned to the client. We will contact you immediately if this occurs. If your case is in active status, your retainer is expected to be replenished within 48 business hours. If you do not respond to our email and phone call informing you of the need to replenish your retainer, signing this form permits the office of Karen Wood, LMHC to charge your credit card on file for the balance due to return to \$2,000.00. If your retainer balance falls below \$300.00, you do not reply to our communication and it is 48 business hours prior to your next scheduled

OFFICE OF KAREN WOOD, LMHC

session, that session will be cancelled until the retainer amount is replenished to \$2,000.00; replenishing your retainer is necessary regardless of the clients' intent to pay cash or check for that session. Client agrees to continue to keep retainer current until the therapist is removed from the case; the therapist can continue to work on the case until the day a formal removal from the judge is received. Time is billed for all orders for records, including archive retrieval, copies, faxes, explanation of notes due to shorthand/abbreviations commonly used in mental health and any other requests such as summaries, faxing/scanning. No information shall be released prior to payment for such services. The client will be provided with an itemized statement monthly or at the time your retainer falls below \$300.00. All services will be suspended until the retainer is replenished. If a credit card is placed on file, we will give 48 hour notice before charging the fee. Please call within the 48 hour window if you do not wish the card to be charged.

4. Service Fees

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 \$175.00 per hour charged at one-tenth of an hour. Deposition and court appearance preparation, travel and testimony, whether telephonic or in person, will be charged for at a rate of \$250.00 per hour charged at one-tenth of an hour. These services are NOT covered by your insurance plan. A minimum of two weeks' notice is required. Any court appearance or deposition request with less than 2 week notice will be charged at \$300 per hour for preparation, travel and appearance.

5. Court Appearances

All subpoenas for court appearance or deposition must be made with a minimum of two weeks notice. No depositions shall occur in this 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 (unless specifically stated by the judge) and a minimum of 90 minutes of travel (for Broward Court's) must be paid for prior to the therapist agreeing to appear. A separate agreement is attached and will be used in the event that I am asked to appear. I will not appear unless this form is signed. No preparation will begin until payment is made. These services are NOT covered by your insurance plan. Any appearance request with less than 2 weeks notice will be charged at \$300 per hour for preparation, travel and appearance. Phone appearances are negotiated at the same preparation and appearance rate and based on the length of the hearing.

6. Cancellation of sessions without 48 hours' notice are the financial responsibility of the party that cancelled unless otherwise agreed to in writing and are billed at \$175.00 per session.

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

Print Name _____ Date _____
Client

Signature _____ Date _____
Client

Print Name _____ Date _____
Attorney

Signature _____ Date _____

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

Case Name: _____ Name: _____

Please initial either "yes" or "no" below

- _____ YES 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.
- _____ NO

The party requesting this deposition/appearance must sign this form agreeing to the following terms prior to confirmation of appearance.

Deposition and/or court testimony, preparation and travel time \$200/hour calculated in 10 minute increments with two weeks notice. \$300 /hour with less than two weeks notice.

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. 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.
5. Time spent testifying at deposition/appearance does not include time spent reviewing records to prepare for the deposition. Arrangements to review records prior to scheduling a deposition must be made in advance and time spent reviewing records will be paid at the rate of \$250 per hour. Preparation of a minimum of two hours is mandatory. Any preparation with less than 2 weeks notice will be charged at the rate of \$300 per hour. No preparation will occur until payment is made.
6. 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 for Broward cases. Cases outside of Broward will be adjusted accordingly.
7. Depositions/Apearances shall not be scheduled in Karen Wood's office as it does not accommodate for this activity.

By signing below, the attorney and client 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. The full fee must be paid at least two weeks 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

Initials _____

FOR OFFICE USE

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.

Initials _____

OFFICE OF KAREN WOOD, LMHC

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: _____

GAL name and phone number: _____

Child Name: _____ Birth Date: _____ School: _____

Child Name: _____ Birth Date: _____ School: _____

Child Name: _____ Birth Date: _____ School: _____

Initials _____

OFFICE OF KAREN WOOD, LMHC

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	_____	()_____
Psychiatrist	_____	()_____
Other	_____	()_____
Other	_____	()_____
Other	_____	()_____
Other	_____	()_____
Only when ordered or subpoenaed:		
Honorable Judge	_____	()_____

Parent Name – Print

Date

Parent Name – Signature

Date

Initials_____

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: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> 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, replenishment of retainer with 48 hours notice and associated charges as agreed below. **Please note if your retainer has been paid by other means and a credit card is not on file your initials and signature are still required on this page.** These charges may include:

____(initials) All court involved and disability clients are required to pay and maintain a **\$2,000.00** retainer .

____(initials) Payment for sessions not covered by insurance: **\$175.00** per session

____(initials) Charge for cancellation without 48 hours' notice: **\$175.00**

____(initials) Charge for a no-show appointment: **\$175.00**

____(initials) Phone sessions, emails, texts and emergency phone calls are billed at the rate of **\$175.00** per hour.

____(initials) Court appearance/deposition related services including preparation, travel and appearance **\$250.00/\$300.00** per hour dependent on if Karen Wood, LMHC is informed with more or less than two weeks notice.

____(initials) Client agrees to continue to keep retainer current until the therapist is removed from the case; the therapist can continue to work on the case until the day a formal removal from the judge is received. Time is billed for all orders for records, including archive retrieval, copies, faxes, explanation of notes due to shorthand/abbreviations commonly used in mental health and any other requests such as summaries, faxing/scanning. No information shall be released prior to payment for such services.

____(initials) Use of a credit card will result in a **4%** administrative fee. Cash, check, Venmo or Zelle 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 or attorney used to collect said fees. 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 end of this case.

Signature of Authorized Credit Card Holder: _____ Date: _____

Initials _____

OFFICE OF KAREN WOOD, LMHC

FINANCIAL POLICY

If you fail to meet your financial responsibilities, your account may be turned over to a collection agency, an attorney 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 forty-eight (48) hours advance notice if unable to keep the scheduled appointment. **In the event that I do not provide the forty-eight (48) hour notice prior to cancelling, I am responsible for the reserved appointment at the rate of \$175.00.**

I understand that court ordered cases are not protected under HIPAA. Any information requested by the courts can and will be released if subpoenaed.

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 UNLESS OTHERWISE STATED BY A COURT ORDER (ex. Reunification). 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 48-hour notice of cancellation of appointments to avoid being charged a missed appointment fee of \$175.00 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.

5. Sessions are an average of 45 to 50 minutes in length.
6. 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.
7. Emails and texts are also billable and not covered by insurance.
8. 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 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 seventy five dollars (\$175.00) per hour and court appearances/depositions door to door at a rate of two hundred and fifty dollars per hour (\$250) charged at one-tenth of an hour including preparation time and travel. These services are NOT covered by your insurance plan.**
11. **Please be advised that all court involved cases require a retainer of \$2,000.00 (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 4% will be charged to you in addition to the \$2,000.00 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 \$2,000.00; replenishing your retainer is necessary regardless of the clients' intent to pay cash or check for that session. Client agrees to continue to keep retainer current until the therapist is removed from the case; the therapist can continue to work on the case until the day a formal removal from the judge is received. Time is billed for all orders for records, including archive retrieval, copies, faxes, explanation of notes due to shorthand/abbreviations commonly used in mental health and any other requests such as summaries, faxing/scanning. No information shall be released prior to payment for such services. 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 \$2,000.00. 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. The non-reunifying parent must also not be on the premises of any off site visitations unless it is time to pick up the child. Karen Wood, LMHC will provide a cell phone number where she can be reached at any time if there is an emergency during visitation. 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.

Print Name

Signature

DATE: _____

Initials _____