

GILBERT
 2563 S. Val Vista Road St. 108
 Gilbert, AZ 85296
 480-448-1076



PHOENIX
 1440 E. Missouri Ave. Suite 270
 Phoenix, AZ 85014
 info@infinitehw.com

NEW CLIENT PAPERWORK

I am here to see the following care provider:

- | | |
|--|--|
| <input type="checkbox"/> Julie Russomanno, Life Balance Therapies PLLC | <input type="checkbox"/> Deana Charter, Next Step Counseling LLC |
| <input type="checkbox"/> Dr. Chante Pantila, Creating Changes PLLC | <input type="checkbox"/> Julie McAllister, Sonoran Sage Counseling PLLC |
| <input type="checkbox"/> Kelly O'Horo, Infinite Healing and Wellness S-Corp | <input type="checkbox"/> Nate Perrizo, Infinite Healing and Wellness S-Corp |
| <input type="checkbox"/> Courtney Glenny, Infinite Healing and Wellness S-Corp | <input type="checkbox"/> Dr. Valdez, Infinite Healing and Wellness S-Corp |
| <input type="checkbox"/> Janine Faux, Infinite Healing and Wellness S-Corp | <input type="checkbox"/> Jessica Hagan, Infinite Healing and Wellness S-Corp |
| <input type="checkbox"/> Amy Bednarski, Infinite Healing and Wellness S-Corp | <input type="checkbox"/> Alex McAuslan, Infinite Healing and Wellness S-Corp |
| <input type="checkbox"/> Jessica Novoa, Infinite Healing and Wellness S-Corp | |

Full Name			Date	
Street Address		City	State	Zip Code
Home Phone		Work Phone	Cell Phone	
*Social Security Number		Birth Date	Age	
Race and/or Ethnicity	Sexual Orientation	Gender	Religious Affiliation	
Email		Highest Level of Education Attained		
Employer (if employed)		Job Title (if employed)		
Relationship Status		In case of emergency, please notify (provide name and phone #):		

Please provide the following health information.

Primary Care Doctor	Primary Care Doctor's Phone #
List Any Current Medical Problems	
How much do you usually smoke?	How much alcohol do you usually drink?
How much caffeine do you drink per day?	Do you take vitamins and/or herbal supplements? Yes No
How often do you get 20 minutes or more of exercise?	Do you regularly practice relaxation techniques (e.g., meditation, yoga)? Yes No

How did you find IHW? (Doctor referral, friend, internet, etc.) _____

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Current Concerns

Below is a list of commonly experienced concerns. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item is presently a concern for you using the following scale:

Not at all Mildly Moderately Quite a bit Very much
 0 1 2 3 4

1. Dealing with stress or pressure		2. Someone else's habits or behaviors	
3. Adjusting to a new work or living environment		4. Unwanted/out-of-control behaviors or habits	
5. Feeling depressed, sad or down		6. Problems with assertiveness or shyness	
7. Establishing a career direction		8. Sleep problems	
9. Death or illness of a significant person		10. Rape, sexual assault or sexual harassment	
11. Performance anxiety, work or academic progress		12. Eating problems (bingeing, restricting, low appetite, vomiting, laxative use, etc.)	
13. Time management		14. Relationships with romantic partner/spouse	
15. Difficulties related to sexual identity or sexual orientation		16. Physical health problems (headache, pain, fainting, injury, fatigue, etc.)	
17. Feeling anxious, fearful, worried or panicky		18. Sexual matters (pregnancy, sexually transmitted disease, sexual functioning, etc.)	
19. Feeling unmotivated, procrastination or difficulty concentrating		20. Urge or plan to harm another person	
21. Feeling irritable, tense, angry or hostile		22. Relationships with supervisors or instructors	
23. Relationships with family members (parents, siblings, children, relatives)		24. Suicidal thoughts and feelings	
25. Money, finances		26. Racial, sexual or other discrimination	
27. Feeling lonely, isolated or uncomfortable with others		28. Feelings of guilt or self-criticism	
29. Values, beliefs, religion or spirituality		30. Weight or body image problems	
31. Past sexual experiences (sexual abuse, incest, unwanted sexual behavior)		32. Your use of alcohol, drugs or other substances	
33. Low self-esteem or self-confidence		34. Unusual perceptual experiences (hearing voices, seeing things, etc.)	
35. Legal matters		36. Other _____	

Were you adopted? YES NO	Have your parents ever been divorced? YES NO If Yes, when?	Are both parents still alive? NO YES
Any history of mental illness such as depression or anxiety in your family? YES NO	Any history of suicide in your family? YES NO	
Any family history of drug or excessive alcohol use? YES NO	Any history of abuse in your family? YES NO	
Have you or any members of your family had legal problems? YES NO	Have you ever served in the military? YES NO If Yes, which branch?	

Please describe your reasons for seeking counseling/therapy at this time:

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PAYMENT INFORMATION: (Can be shared over the phone prior to 1st appointment)

Your card will be charged on the day of your appointment unless you prefer to pay with cash or check. The card will be kept on file and your receipt will be emailed to you. Please note that if you cancel your appointment with less than 24 hrs. notice, or are a “no-show”, you will be subject to a full session fee, even for first appointments. For this reason, we require that a credit card be kept on file, even in the event that you prefer to pay for services with cash or check.

Client

Signature

Payment Preference

Name on Credit Card to be charged the day of the appointment.	Visa _____ MC _____	Card Number
	AMEX _____ Discover _____	

Please let us know if you prefer to pay for services using cash or check.

I prefer to pay for services using cash.

I prefer to pay for services using a check.

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Informed Consent Signature Page

TO BE SIGNED and KEPT ON FILE

I have read and reviewed the Informed Consent including: Office Policies and General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy *carefully* (a total of 6 pages); I understand them and agree to comply with them:
X Received copy via email with written or verbal permission of complete Informed Consent including 20 items below in detail. In addition, reviewed items at Intake Appointment with clinician.

CONFIDENTIALITY, WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW, EMERGENCY, HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS, LITIGATION LIMITATION, CONSULTATION, E-MAILS, CELL PHONES, COMPUTERS AND FAXES, RECORDS AND YOUR RIGHT TO REVIEW THEM, TELEPHONE & EMERGENCY PROCEDURES, PROFESSIONAL FEES, MEDIATION & ARBITRATION, THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE, TREATMENT PLANS, TERMINATION, DUAL RELATIONSHIPS, SOCIAL NETWORKING AND INTERNET SEARCHES, CANCELLATION, RECEIVED COPY VIA EMAIL OF NOTICE OF PRIVACY PRACTICES (HIPPA INFORMATION), INFINITE HEALING & WELLNESS S-CORP ROLE AS A MANAGEMENT COMPANY

Print name of Client or Parent/ Guardian Date

Signature of Client or Parent/ Guardian Date

Print name of Clinician Date

Signature of Clinician Date

PROVISIONS FOR SERVING AS A TREATING CLINICIAN WITH MINORS The client of record is a minor N/A
(I have read and agree to terms in this section)

Signature of Parent/ Guardian Date

Signature of Parent/ Guardian Date

PAYMENT POLICY (I have read and understand the payment policy and authorize the charge by company indicated)

Infinite Healing and Wellness S-Corp

Life Balance Therapies PLLC

Next Step Counseling LLC

Creating Changes PLLC

Sonoran Sage Counseling PLLC

Signature of Client or Parent/Guardian Date

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Informed Consent for Psychotherapy Services

Office Policies & General Information Agreement for Psychotherapy Services or Informed Consent for Psychotherapy. Informed Consent Signature Page must be signed following review, prior to first appointment. *This form provides you, the client, with information that is additional to that detailed in the [Notice of Privacy Practices](#) and it is subject to HIPAA preemptive analysis.*

CONFIDENTIALITY: All information disclosed within sessions and in the written records pertaining to those sessions, are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED, OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to the therapist that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by the therapist. In couple and family therapy, or when different family members are seen individually, even over a period, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. The therapist will use his/her clinical judgment when revealing such information. Your therapist will not release records to any outside party unless s/he is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you are receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the person whose name you have provided on the biographical sheet.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on the therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

CONSULTATION: Your therapist consults regularly with other professionals regarding his/her clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

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E-MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes are vulnerable to such unauthorized access since servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on your therapist's laptop is encrypted, e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. The therapist's laptop is equipped with a firewall, a virus protection and a password, and he backs up all confidential information from his computer on a regular basis onto a HIPPA compliant cloud storage service. Also, be aware that phone messages are transcribed and sent to the therapist via unencrypted e-mails. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and he will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of your therapist's profession require that s/he keep treatment records for at least 6 years. Unless otherwise agreed to be necessary, he/she retains clinical records only as mandated by Arizona law. If you have concerns regarding the treatment records, please discuss them with your therapist. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when he/she assesses that releasing such information might be harmful in any way. In such a case, he/she will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all the above exclusions, if it is still appropriate, and upon your request, he/she will release information to any agency/person you specify unless the therapist assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, the therapist will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: You may leave messages with us at any time on our 24-Hour voicemail system. Your therapist will respond as soon as he or she is able. If you are in a situation where you need to speak with someone immediately, please call 911, or the crisis hotline at (480) 784-1514. If a call with your therapists takes more than a few minutes, the therapist will assess a pro-rated charge. **Initial Here _____**

PROFESSIONAL FEES: Our therapy charges are based on current and customary fees for this area. We have agreed that your fee(s) for professional services are **\$_____** per individual/couples/family session. Payment is due at the time services are rendered either by Cash, Check, or Credit Card. A card must be kept on file for the possible Late Cancel or No Show that is inside the 24hr cancellation time. In addition, there is a \$4 service fee to use all credit cards.

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Additionally, consultations with other professionals and reports prepared on your behalf will be charged a prorated fee. Assessment testing is charged on a per instrument basis. A \$25 charge is made for any check returned to us as non-payable for any reason. Accounts over 90 days past due may be sent to collections and additional fees may be applied.

In addition to weekly appointments, my hourly fee for other professional services you may need including: report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service that you may request of me. If you become involved in legal proceedings that require my participation (see provisions for serving as a treating clinician), you will be expected to pay for my professional time, including preparation and transportation costs. Because of the complexity of legal involvement, I charge \$325 per hour with a four-hour minimum requirement for preparation, travel time and attendance at any legal proceeding. In addition, this fee will need to be paid in advance. Please notify your therapist if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Since we are an out-of-network healthcare provider, we are limited in billing insurance for treatment; however, you can obtain a "superbill" which is a type of receipt that you can submit to your insurance company for reimbursement.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Arizona in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, the therapist can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or

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disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, adaptive information processing used when employing EMDR, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. Your therapist provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within his/her scope of practice.

TREATMENT PLANS: Within a reasonable period after the initiation of treatment, your therapist will discuss with you his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first couple of meetings, the therapist will assess if he/she can be of benefit to you. The therapist does not work with clients who, in his/her opinion, he cannot help. In such a case, if appropriate, he will give you referrals that you can contact. If at any point during psychotherapy your therapist either assesses that he is not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, he will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, he would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, the therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will give you a couple of referrals that you may want to contact, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, your therapist will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. Your therapist will assess carefully before entering into nonsexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either

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unavoidable or expected. The therapist will never acknowledge working with anyone without his/her written permission. Many clients have chosen one as their therapist because they knew him/her before they entered therapy with him/her, and/or are personally aware of his/her professional work and achievements. Nevertheless, the therapist will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise your therapist if the dual or multiple relationship becomes uncomfortable for you in any way. The therapist will always listen carefully and respond to your feedback and will discontinue the dual relationship if s/he finds it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, A full session fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions. **Initial** _____

INFINITE HEALING & WELLNESS S-CORP ROLE AS A MANAGEMENT COMPANY: Infinite Healing & Wellness S-Corp employs the owner, Kelly O'Horo, LPC. All other clinicians work as independent contractors or independent companies and use the management services offered by Infinite Healing & Wellness S-Corp. Clinicians who work in the building leased by Infinite Healing & Wellness S-Corp are not franchisees but are tenants subletting space from the management company Infinite Healing & Wellness S-Corp.

PROVISIONS FOR SERVING AS A TREATING CLINICIAN WITH MINORS: When caretakers bring their children for assessment and treatment of psychological problems it is preferable that both parents consent to treatment knowing that the role of the clinician is as the family or child therapist and not as an expert witness. Prior to beginning treatment, it is important for you to understand my approach to child and adolescent therapy and agree to some rules about your minor's confidentiality during his/her treatment. The information herein is important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health

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professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. I will encourage your child to regularly provide you with a summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future. In addition, I will periodically request that you provide supportive information in order for me to best help your child and the family.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

In signing this agreement, I acknowledge that there is a difference between the roles of treating clinician and expert witness, and I agree not to subpoena the clinician, nor the clinician's records for use in litigation. I understand that the boundary between treating clinician and expert witness is necessary so that the treating clinician may maintain the integrity of the therapeutic relationships established through therapy. In addition to the information contained in the Outpatient Services Contract, under HIPAA and my Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.