44444 Mound Road, Suite 620, Sterling Heights, MI 48314
Phone: 586.859.0030

Contract for Court-Related Services
Informed Consent / Financial Responsibility Form

I, _____, voluntarily consent to the following court- related service(s) with Janice Kizy, LMSW of Mind and Spirit Counseling.

Initial service being requested below:

*_____ Parenting Time Coordination - Court-Ordered intervention in decision-making for children where specific stipulations are set forth by the Court for Janice Kizy, LMSW to resolve disputes of the family. The scope of this work is determined through a specific Court Order naming Janice Kizy, LMSW of Mind and Spirit Counseling as the Parent Coordinator that must be signed by both parties.

*_____ Co-Parenting Counseling – Court-Ordered educational and therapeutic intervention to improve the Co-Parenting relationship through learning about the positive impact of cooperative Co- Parenting on children and striving toward effective communication to improve Co-Parenting in two homes.

*_____ Reunification Therapy – Court-Ordered therapeutic intervention for families in two homes when the child(ren) find difficulty visiting with and/or having a positive relationship with one parent.

I am aware of the reasons for these services. I also understand that these services differ from traditional mental health services in the following ways:

1. Limits to Confidentiality
I am aware that these services are not confidential. Anything I say might be quoted in a written report. If these serves are court-ordered, reports or treatment updates will be released to the agency requesting these services. I am also aware that the clinician may discuss my case with other professionals clearly involved with these services or while participating in quality improvement activities. I understand that there are specific situations when the clinician will be required to report to appropriate authorities any information I reveal that clearly indicates a danger to myself or others (e.g. potential suicide or homicide). My clinician is also required by law to report any knowledge of abuse or neglect of a child, or of an incompetent, disabled, or otherwise restricted person.

2. Impartiality
I understand that the clinician will describe the results of services in an impartial and professional manner. I am aware that payment for these services in no way guarantees a favorable outcome for either party.

3. Dual Relationship Statement
I understand that other forms of psychological services beside those endorsed above may not be provided by the same clinician. This is to prevent a potential conflict of interest that could result in my not getting full benefit of the above indicated services.

4. Access to Records
I am aware that while I have the right to information regarding any records of shared appointments with other adults I am participating in this service with, I will not have access to information gathered during individual appointments with that adult or a record of their billing and appointment attendance. I

understand that biological parents/legal guardians of any minor children participating in counseling may have a right to access their medical record, unless limited by court order or as permitted or required by law, and in some circumstances not disclosed as determined in the professional judgment of the therapist.

5. Payment
I understand that I am responsible for payment of all charges due for services rendered. I understand that a copy of reports may not be sent until services are paid in full, and that additional reports may be subject to charge. I understand that I will be billed at a rate of $200/hour in 15-minute increments for all non-session professional activities such as review of collateral information, review of ongoing correspondence or communication with health or legal providers related to the case.

6. Retainer
For intervention services (e.g. Parent Coordination, Reunification Therapy) a retainer of $500 shall be provided by the client at the outset of services. If more than one client is participating in services, the expense of the retainer shall be split according to the order for said services or the Judgment of Divorce if no specific service order exists. The retainer will be charged for non- session professional activities such as review of collateral information, review of ongoing correspondence or communication with health or legal providers related to the case. The retainer will be charged episodically, typically on a monthly basis. A full report of professional activities can be requested at any time. When the retainer account falls below $200, a replenishment will be required. If the balance falls to zero the services may be suspended. At the end of the service provision any unused amounts shall be returned according to the portion paid.

7. Cancellation Policy
I am aware that if I cannot attend a set appointment, I need to give notification at least 24 hours in advance. If I do not give 24-hour notification, I am aware that I will be responsible to pay a fee of $200. If participating in Co-Parenting Counseling, the parent who cancels the appointment without 24-hour notification will be charged the $200 fee.

8. Duration of Consent
I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional services rendered, or until such authorization is revoked in writing. I understand that any written or verbal disclosures made prior to revocation of consent are not subjected to confidentiality, since such information has already been released.

9. Practical Issues
I have been made aware of reasons I might be discharged from services, including missing two or more consecutive appointments without 24-hour notification, inappropriate or threatening behavior toward the clinician or other participants in sessions, inappropriate or threatening emails or phone calls to the clinician, lack of sincere effort and cooperation toward scheduling appointments or working toward the goals determined by the court and/or clinician and any other behavior that the clinician deems counter-productive to the process. I understand that there is no guarantee the services I receive will bring the desired result.

I, the undersigned do hereby understand and voluntarily consent to the terms and conditions described above. I have had the opportunity to have my questions answered prior to signing this form.
Please ensure you have selected and initialed the appropriate service listed near the top and complete the form below providing general information.

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Client Intake Form

GENERAL INFORMATION Today's Date: _____

First Name: Middle initial: Last Name:	Co-Parent Name:
Birthdate: Age:	Gender: [ ] Male [ ] Female
Street Address:	City: State: Zip:
Home Phone:	May we leave a message [ ]Yes [ ] No
Cell Phone:	May we leave a message [ ]Yes [ ] No
Email Address:	
*Please note: Email correspondence is not considered to be a confidential medium of communication.	
How did you hear about Mind and Spirit Counseling:	

Emergency Contact:

Name: _____ Relationship: _____ Phone#: _____

Place of Employment: _____

Title: _____ Duration of Employment_____

Names of Any Legal Professionals You Have Engaged for Divorce and Legal Services:

Name of professional: _____	Name of professional: _____
Address: _____	Address: _____
_____	_____
Phone Number: _____	Phone Number: _____

Name of Therapists (If Applicable): _____

_____

Which Judge is assigned to your case? _____

List any professionals from Friend of the Court you are working with: _____

Information on Shared Children:

Name	Age	Date of birth	Sex

Please provide any additional information about shared children here: _____

_____

_____

Information on Non-Shared Children:

Name	Age	Date of birth	Sex

Please provide any additional information about Non-shared children here: _____

_____

_____

Names of Therapists You Have Engaged the Services of for your Children (If Applicable): _____

_____

Signature of person completing form: _____

Printed Name: _____ Date: _____

Therapist/Coordinator Signature: _____ Date: _____