

JoAnne Seawell, LPC, LMFT

13801 Village Mill Drive, Suite 105

Midlothian, Virginia 23114

Phone: (804)909-2803

Fax: (804) 794-0838

seawell.joanne@gmail.com

www.joanneseawell.com

Adult Registration Form

All information will be treated confidentially

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email _____

Age: _____ **Birth Date** _____ **Gender** _____ **Marital Status** _____

Occupation _____ **Highest level education** _____

Employer _____

In Case of emergency contact _____

Physician name and number _____

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Co-Parenting Packet:

Co-parenting:

- 1. Either occurs before the divorce is finalized or after.*
- 2. The therapist does not have decision making authority in settling disputes*
- 3. The therapist has no specific time limit for the role*
- 4. The therapist focuses on developing a parenting plan or working out specific conflicts with regard to the interpretation of the parenting plan.*
- 5. It is not covered by HIPPA and is not a confidential process*
- 6. It requires training and experience but is not considered therapy.*
- 7. Both parents must sign designated co-parenting.*

The packet includes:

- 1. Co-parenting agreement*
- 2. Adult Registration Form*
- 3. Informed Consent to Treatment Agreement-completed by all clients*
- 4. Agreement to participate in credit//debit card on file policy*

Co-Parenting Agreement

Court Involvement:

Because you are seeking help in a situation where the Court may be involved, please be aware that these records may be subpoenaed by the Court or by one of the attorneys involved in the case. Please address any concerns you may have about these issues at any point during your work with me.

Confidentiality:

Because of the nature of this therapy, there is a possibility that I may be subpoenaed to Court. As a result, confidentiality is limited to the degree that this may occur, especially as it pertains to your children and/or your cooperation in the co-parenting process. By signing this release, you are NOT waiving your rights to confidentiality. This is simply a notification that our discussions and my professional opinion may be subpoenaed to Court.

Case Consultation:

Due to the difficult nature of co-parenting therapy, I may seek consultation with my peers if applicable. Any identifying information will be removed from the case material. If you have any questions about this consultation, please do not hesitate to ask.

The following outlines my fees for any Court related services. Please be advised that by signing this document, you are agreeing to pay for these services in full should you decide to exercise them.

1. Co-parenting sessions are approximately 45-50 minutes in length. The regular 45-50 minute session is \$180.00 90-minute sessions are \$225.00 and two-hour sessions are \$360.00.
2. Email and phone calls on topics other than setting up appointments are billed at the rate of \$45.00 per 15-minute increments.
3. Conversations with the children's therapist and/or the Guardian ad litem are not charged. However, any conversations with attorneys are billed at the rate of \$45.00 per 15-minute increments. If the attorney has asked for a block of time for this discussion, you will be billed for that entire time regardless of how long the phone call occurs because I have had to block off this time for the phone contact.
4. Preparation for Court reports and/or letters, attendance at pre-trial conferences or dispositions, and telephone conferences are all billed at the rate of \$150.00 per hour in 15-minute increments. Any travel time is billed at the same hourly rate.
5. Copying charts are charged at a rate of .50 cents per page plus a \$20.00 handling fee.
6. Any court appearance is \$1,500. This must be paid one week prior to court.
7. For settlements or continuations in which I have not been given 48 hours' notice, I will bill for the time blocked off for Court at the rate of \$ 150.00 per hour.

_____ Initials

8. Sometimes due to the complexity of a case, I will request a deposit, which is due at the first appointment. If requested, the deposit expected from you today is:

9. If there is an agreement which designates the percentage split of costs associated with co-parenting sessions, then we will follow that agreement. Otherwise, the split will be 50/50. Any other expenses will be borne by the party initiating the request and/or subpoena.

10. Missed appointments shall be paid for by the party who has not given 24 hour notice. The charge for missing co-parenting sessions is \$ 180.00

11. There will be a \$25.00 charge for all returned checks. You are responsible for these charges.
12. A service charge of 18% APR will be added to bills that are 90 days past due. If you fail to settle your account, it will be referred to a collection agency and you will be charged for the additional cost of collection, approximately 33 1/3% of the balance due plus court costs.

13. Recording of sessions is forbidden.

14. As your mental health professional, I will disclose no information obtained from your contacts with me or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law:
 - a. Harm to Yourself or Someone Else. If I believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for insuring your safety or the safety of others.

 - b. Vacations and Emergencies. When I am on vacation or away from the office for extended periods of time, because of the complexity of this work, there is no back up clinician access because it is too difficult for someone to intervene who is unfamiliar with your family. If you are unable to reach me, you will need to use other resources like the GAL (if applicable), your attorney etc.

 - c. Consultation. To ensure that I am providing quality care, I sometimes meet with a consultant. In so doing, I do not reveal identifying information I will provide names of my consultants upon request.

Client Signature

Date

Clinician Signature

Date

INFORMED CONSENT TO TREATMENT AGREEMENT

As your mental health professional, I will disclose no information obtained from your contacts with me or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law:

1. It is my policy to provide information to others without your further consent, in certain circumstances:
 - a. Harm to Yourself or Someone Else. (If believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for insuring your safety or the safety of others.)
 - b. Vacations and Emergencies. (When I am on vacation or away from the office for extended periods of time, a colleague may cover for my practice and take emergency calls. If she/he will need information to assist you in my absence, I will provide it without using your name: you and I will discuss that plan in advance.)
 - c. Consultation. (To ensure that I am providing quality care, I sometimes meet with a consultant. In so doing, I do not reveal identifying information. will provide names of my consultants upon request.)
2. Virginia law requires psychologists to release information to others in certain circumstances:
 - a. Virginia therapists are required by law to remain certain information:
 - i. Suspicion of abuse or neglect of a child or of an aged or incarcerated adult must be reported to the Board of Social Services.
 - ii. Information that a Psychologist is engaging in unethical or illegal practice must be reported to the Board of Psychology.
 - iii. If you are licensed by a Health Regulatory Board, I am required to report that you are receiving therapy if I believe that your condition places the public at risk.
 - b. Virginia law imposes upon therapists the legal duty to protect other members of society from harmful actions by their patients. Voiced threats of direct harm to another person can result in notification of the potential victim, law enforcement officers, and/or others as specified by statute.
 - c. In Virginia court cases. therapist-patient privilege may not apply in certain cases, including:
 - i. Criminal cases
 - ii. Child abuse cases
 - iii. Any court case in which your mental health is an issue, and/or
 - iv. Any case in which the judge "in the exercise of sound discretion deems it necessary to the proper administration of justice." This means that information communicated to a therapist can be admitted as evidence in a COM case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either Department records or testimony from your present or former therapist as evidence in a court case (including child custody cases). If I receive such a subpoena, I will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash the subpoena and requesting that the confidentiality of the therapy relationship be protected. However. only the judge may decide whether the requested information or records must be disclosed.

_____Initials

- d. Virginia law allows certain others to request access to treatment records in specific circumstances. Including
1. Protective Service Workers to whom I have reported suspicion of abuse or neglect, if they so request;
 2. Court-Appointed Special Advocates in child abuse or neglect proceedings, if the court so orders and 3) Evaluators for minors' involuntary commitment to inpatient treatment, if they so request
 3. In such cases, I will make every attempt to limit the information disclosed by substituting an oral or in person rather than submit actual treatment records.
- e. If you are under 18, Virginia law allows your parents to obtain information and/or records related to your treatment. There is an exception to this if you are in treatment for drug or alcohol abuse (substance abuse).

Client Signature

Date

Clinician Signature

Date

AGREEMENT TO PARTICIPATE IN CREDIT/DEBIT CARD ON FILE POLICY

Your provider requests that you keep a credit or debit card on file (which is kept confidential in accordance with HIPAA standards and regulations at all times) as a convenient method of payment for the portion of services that your insurance does not cover, as well as any other services or fees for which you are responsible. Your signature authorizes your provider to charge this card for the any remaining balance for services as outlined in the Financial Agreement.

Before your card will be charged, you will receive a mailed invoice itemizing the charges. These expenses will be applied to your card after a minimum of 10 business days from the time the invoice is sent out. Unless you have decided with our billing office for a payment plan your card will be charged the full amount of any remaining balance due. Requests for payment plans must be made in writing to our billing office and approved by your provider at the address below.

***13801 Village Mill Drive, Suite 105
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I _____ authorize my provider to charge the portion of my bill that is my financial responsibility to the following credit or debit card: I understand that my information will be saved to file for future transactions on my account.

Visa, Master Card, American Express, Discover

Card Number: _____

Expiration Date: _____

CCV Code on back of card: _____

Name as it appears on card: _____

Credit Card Billing Address Street Name and Number: _____

City: _____ State: _____

Zip Code (from credit card billing address): _____

I (we), the undersigned, authorize and request my (our) clinician to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for psychological services. This authorization will remain in effect until I (we) cancel this authorization. To cancel, (we) must give a 60-day notification to our billing office in writing and the account must be in good standing.

Card Holder Name (Print): _____

Card Holder Signature: _____

Date: _____