

Carol R. Hirshfield, PhD.

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REUNIFICATION THERAPY AGREEMENT

This agreement is made between _____ and _____, hereinafter referred to as “the parties” and the therapist, Dr. Carol Hirshfield to specify the services provided by the therapist and the expectations of “the parties” in this process. By signing this agreement, the parties agree to participate fully in this process.

Goals of Treatment

Both parents agree that the following goals will be addressed:

1. **Family members to be included:** Both parents agree to be actively involved in the process, including allowing the therapist to determine who will attend sessions.

Sessions may include any combination of the following: one parent, one parent and the child(ren), or both parents without the child(ren).

2. **Reunification therapy involves working toward eliminating parental estrangement, parental alignment or alienation, and will involve the following:**

- a) Psychotherapy for _____ (co-parenting, or individual therapy for adults, child(ren) family, etc.)_____

b) Specific behavioral interventions:

3. Developing Parenting plan modifications _____

4. Other: _____

Confidentiality and Reports to the Court.

There shall [] shall not [] be a direct report to the court regarding progress in therapy. Also, as per court order, recommendations can be made regarding physical custody, visitation, or other issues regarding well-being of the child(ren). Both parents will be informed about any recommendations in advance of their being made to the Court.

If there is no report to the court, the therapy may be considered confidential for the purposes of any future court hearings or evaluations regarding custody matters.

The therapist may [] may not [] communicate in a simultaneous conference call with attorneys regarding this case. Such a conference call will be made with full consent of both parents in advance of such conference call.

Dr. Carol Hirshfield shall [] shall not [] have access to any evaluation reports, court filings or declarations that have previously been done regarding this case.

Dr. Carol Hirshfield may [] may not [] communicate with other family member's individual psychotherapists. Communication with outside parties will only be done with specific signed consent by both parties to give or receive information about themselves or their children.

Recording or videotaping sessions. I understand that no session may be electronically recorded by audio taping, videotaping, or any other means by Dr. Hirshfield or any parties in the room for the session without their explicit agreement to do so.

Fees. The hourly rate for this service is \$ 250. The parties should arrange for payment of the deposit within five days prior to the initial session. The estimated deposit is based on 2 sessions of 2 hours each, or \$ 1000. If documents are to be reviewed, additional charges will be added to the deposit, with notification to both parties. Further sessions are to be paid at the time of service. All unused fees will be refunded.

The cost of the therapy shall be paid as follows: _____1/2 by each party; or other:
_____. Payment should be made in the form of a cashier's check made payable to Carol Hirshfield, PhD, 11340 W. Olympic Blvd., Ste. 265, Los Angeles, CA 90064 or by credit card authorization (Form follows).

Authorization is requested for credit card payment of any fees not paid at the end of a calendar month or within one month of receipt of the statement. Provide information and sign the authorization on the form attached. In the event there is any problem collecting fees from either party, an interest charge of 1% of the outstanding balance will be accrued. In the event that costs are incurred in collecting outstanding fees, such costs will be the responsibility of the client.

Professional fees will be charged for all direct sessions, sessions with each party, and any phone calls or writings required in the course of the mediation, including but not limited to communication with the parties, their attorneys, collaterals (teachers or other psychotherapists), or the court.

Cancellation of all sessions must be made within 48 hours (two business days) in advance, or the fee for the session will be charged to the party making the cancellation.

We, the undersigned have read the above fee policies and procedures and agree to abide by them. I agree to authorize payment for any fees outstanding at the end of any month on the authorization form attached.

Dated: _____ Signature: _____

Print Name: _____

Dated: _____ Signature: _____

Print Name: _____

