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Welcome to New Leaf Resources!

The staff at New Leaf Resources are committed to instilling *hope*, providing *help*, and promoting *healing*. Personal growth and change may be difficult at times. Your therapist will provide a safe and supportive environment and will walk beside you on your journey towards healing.

New Client Paperwork

Please complete these forms and give the packet to your therapist at your first appointment.

1. Client Information (2 pages)
2. Client Commitment (1 page)

3.1 Clients 12 - 17: Adolescent Data Sheet (3 pages) - **to be filled out by the adolescent client**

3.2 Parents of Adolescent Clients 12 - 17 Data Sheet (7 pages) - **to be filled out only by the parent/legal guardian of the client**

4.1 For Clients 3 - 17: Minor Consent Form (1 page) - **to be filled out only by the parent/legal guardian of the client**

4.2 Parent of Client Consent (2 included) - **one required for each parent**

5. Divorce/Separation Agreement (2 pages) - **parent signatures required**

Privacy Notice Information

The Privacy Notice of New Leaf Resources is available online at www.newleafresources.org and available at each of the NLR offices by request.

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CLIENT INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Is it okay to leave a message? Yes ○ No ○ Text? Yes ○ No ○

Social Security Number _____ Gender: Email: _____

How did you hear about New Leaf Resources? _____ Church Affiliation (if any) _____

IF CLIENT IS A MINOR:

Your Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Is it okay to leave a message? Yes ○ No ○ Text? Yes ○ No ○

Are you the parent/legal guardian of this minor? Yes ○ No ○

IF YOU ARE ATTENDING SESSIONS WITH SOMEONE ELSE:

Their Name _____ Date of Birth _____

BILLING INFORMATION

(Fill this out if the information is <u>different</u> than the client information)

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Secondary Phone Number _____

Social Security Number _____ Gender M ○ F ○

Relationship to Client _____

**New Leaf Resources will send unpaid balances to a collection agency if payment arrangements are not initiated by the responsible party.*

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INSURANCE INFORMATION

(If primary insured is the client—skip to the Primary Insurance Carrier Info)

Name of Primary Insured_____ Date of Birth _____

Address _____ City _____State _____ Zip _____

Primary Phone Number _____ Gender M ○ F ○

PRIMARY INSURANCE CARRIER

Insurance Company Name _____ Phone Number _____

ID Number _____ Group Number _____

SECONDARY INSURANCE CARRIER

At this time New Leaf Resources will not be filing secondary insurance for our clients. We apologize for the inconvenience.

ASSIGNMENT & RELEASE

I select New Leaf Resources (NLR) as my provider of choice. I hereby authorize payment for services directly to NLR. I represent that I have insurance coverage and do hereby authorize NLR to release and obtain all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I acknowledge that NLR has made available to me the Privacy Notice of New Leaf Resources online at www.newleafresources.org and in handout form at each of the NLR offices.

_____ _____

Signature of Client or Parent/Legal Guardian Printed Name

_____ _____

Date Relationship to Client

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FORM #2

CLIENT COMMITMENT

Thank you for choosing NLR as your counseling services provider. We are committed to helping you reach your goals. We ask that you commit yourself to the timely payment of your agreed upon portion of the charge.

FEES

Initial Assessment	$170
Session (1 hour)	$140
Session (45 minutes)	$105
Group Therapy Session (1 hour)	$50/person
Late Cancellation Fee/No Show Fee	$50
Testing	Varies depending on tests administered
Returned Check	$25

We accept cash, checks, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER.

PAYMENT POLICY AGREEMENT (initial each section)

_____ 1. Insurance co-payments are due at time of service.

_____ 2. Payment is due upon receiving your monthly statement in the mail.

_____ 3. I understand that all charges are my responsibility to pay. If I have insurance, I realize that insurance payments do not always cover all fees and that I am responsible for any part not covered.

_____ 4. I understand that appointments not cancelled within 24 hours will be charged a $50 fee.

_____ 5. I understand that if I do not show up for my scheduled appointment I will be charged a $50 fee.

_____ 6. I agree that if any portion of my account balance is over ninety (90) days, it will be considered delinquent for the purposes of collection.

_____ 7. If any portion of my account becomes delinquent (as defined in section 6) and it becomes necessary to institute legal proceedings to collect payment, I further agree to pay the attorney fees incurred through litigation and/or other efforts undertaken to collect such delinquent sums.

I have read and I understand the above policies and agree to abide by them. By signing this commitment form I am agreeing to be the person financially responsible for this client account.

Print Name _____ Signature_____

Name of Client (if different than above) _____ Date _____

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FORM #3.1

Date: _____

Adolescent Data Sheet (ages 12-17)

(For therapist records only)

This form should be filled out by the <u>adolescent</u> receiving therapy.

Your Name: _____ Date of Birth: _____

What brings you in today? _____

_____

Whose idea was it for you to come to this appointment? _____

Have you had any of the following stressors in the last 6 months or in the past?:

Conflicts with family	Recent ☐	Past ☐
Parents Separated	Recent ☐	Past ☐
Parents Divorced	Recent ☐	Past ☐
Changed where I live	Recent ☐	Past ☐
Death of a family member	Recent ☐	Past ☐
Death of a friend/loved one	Recent ☐	Past ☐
Illness of a family member	Recent ☐	Past ☐
Personal injury or illness	Recent ☐	Past ☐
Problems with friends	Recent ☐	Past ☐
Problems at school	Recent ☐	Past ☐
Victim of assault	Recent ☐	Past ☐
Emotional/Verbal Abuse	Recent ☐	Past ☐
Other concerns	Recent ☐	Past ☐

Do you have friend(s) who you really like and feel you can talk to? Yes ☐ No ☐ Not Sure ☐

Do you think that your parent(s) listen to you and take your feelings seriously? Yes ☐ No ☐ Not Sure ☐

Do you have any concerns about your relationship with someone in your family that you want to talk about? Yes ☐ No ☐ Not Sure ☐

Have you had fun during the past two weeks? Yes ☐ No ☐ Not Sure ☐

What were you doing? _____

_____

_____

Below are some questions that will help us understand you better, please check anything that applies to you:

Emotional Concerns

☐ I'm sad or unhappy most of the time ☐ I cry a lot ☐ I'm often tired or out of energy ☐ At times I feel I have nothing to look forward to ☐ I don't seem to care about much anymore ☐ Things in my life are unfair ☐ I have had thoughts of suicide or harming myself ☐ I'm often angry (easily irritated) ☐ I don't enjoy things that I used to ☐ I often don't like going new places ☐ I have a lot of arguments with peers ☐ I have a hard time making decisions by myself ☐ I'm afraid of many things ☐ I worry a lot ☐ I have stolen things ☐ I like/need things to be perfect	☐ I often daydream or get distracted ☐ I forget things ☐ I'm not very confident in myself ☐ I sometimes do things without thinking ☐ I often don't finish things that I start ☐ I'm easily bored ☐ I prefer to be moving over sitting ☐ I have a hard time concentrating ☐ I get in trouble for talking back to adults ☐ I break the rules at home (I disobey my parents) ☐ I have been in trouble with the law ☐ I have thought seriously about running away from home ☐ I have had times I feel in a panic ☐ I prefer to be by myself ☐ I have cut myself or mutilated part of my body (i.e. pulled out my hair)	☐ Peers have been cruel to me in my life (i.e. teasing or bullying) ☐ It's hard to trust other people ☐ People say I'm bossy ☐ I'm sensitive to criticism from others ☐ I wish I had more friends; I'm lonely ☐ Sometimes my looks bother me ☐ I have questions about my sex or my physical development ☐ I love to take extreme risks ☐ I sometimes have thoughts I can't seem to stop ☐ Sometimes I hear things or see things that others can't ☐ I get so angry I have broken things ☐ I check/do certain things over and over ☐ I like to set fires ☐ I have experienced abuse from someone (emotional, physical, sexual)

School Concerns

☐ Other people are disappointed with my grades ☐ School work is difficult for me ☐ I get in *some* trouble at school (i.e. teachers talk to me or detention)	☐ I have been in *significant* trouble at school (i.e. suspension) ☐ I hate going to school ☐ I have often skipped school ☐ My grades this year are worse than last year	☐ I am disappointed with my grades ☐ When I take a test, I can't think ☐ I have a problem with completing/or don't complete my homework

Physical Concerns

☐ I have a lot of aches and pains ☐ I have difficulty sleeping (i.e. nightmares or sleepwalking)	☐ I'm worried about my health or eating habits ☐ I recently have had a big change in my weight or appetite ☐ I need very little sleep

Substance Use

☐ I've got drunk on alcohol ☐ I have close friends who get drunk or high	☐ I've tried marijuana or other drugs ☐ Some people in my family drink or take drugs so much that it worries me

What do you feel are your personal strengths? _____

_____

What are your favorite things to do? _____

_____

What four words best describe you? _____

_____

_____

_____

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Date: _____

Parent Form for Adolescent (ages 12-17)

(For therapist records only)

Personal Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Form completed by: _____ Relationship to client: _____

Contact numbers therapist can call:	Approval to leave a message:	Text:
Cell: _____	Yes ○ No ○	Yes ○ No ○
Other: _____	Yes ○ No ○	
Email: _____	Yes ○ No ○	○ ○

In case of emergency who should be contacted? _____

Primary # _____ Secondary # _____

Parent's Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner ☐

If divorced what are the custody arrangements: _____

_____

What is your reason for seeking counseling for your child at this time? _____

_____

_____

_____

Please tell us about the household/family with which your child spends the majority of his/her time (or who currently lives with your child). List primary household information first, then list other living situations/supportive relationships:

Name	Relation (bio mom, bio dad, step-parent, bio-sibling, step-sibling, etc.)	Age	Living with you?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Do you have significant concerns about your child's relationship with a family member? Yes ☐ No ☐

Please explain: _____

Your Child's Developmental History

Is your child adopted? Yes ☐ No ☐ If yes, at what age? _____

Does your child know? Yes ☐ No ☐

Has your child ever been or currently in Foster Care? _____

Were there any complications with the pregnancy of this child that that might have impacted his/her prenatal health or development? (Mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, et.):

_____

_____

Were there significant concerns with your child's delivery, health, or development in the first few years of his/her life? Yes ☐ No ☐

If yes, please explain:_____

Are there any concerns with your child's **motor development**? Yes ☐ No ☐

If yes, please explain: _____

Age child began crawling: _____ Age child began sitting: _____ Age child began walking: _____

Are there any concerns with your child's **language development**? Yes ☐ No ☐

If yes, please explain: _____

At what age did your child say his/her first word? _____

Are there any concerns with your child's **social development**? Yes ☐ No ☐

If yes, please explain: _____

Does your child have a secure attachment to parent, other family members, and peers?

_____

_____

re there any concerns with your child's **sleep behavior**? Yes ☐ No ☐

Has there been trouble getting to sleep, staying asleep, and how many hours of sleep does your child get per night? _____

Did your child have any difficulty with toilet training? Yes ☐ No ☐

If yes, please explain: _____

Educational History

Where does your child attend school? _____

Highest (or current) Grade Level Achieved: _____

What have been your child's usual report card grades? _____

Any recent changes in grades? Yes ☐ No ☐ If yes, please explain: _____

_____

Has your child experienced any of the following in school?

Learning Problems ☐ Discipline Problems ☐ Social Problems ☐ Emotional Problems ☐

What is your child's learning style (visual, auditory, tactile, etc.)?_____

Does your child have an IEP? Yes ☐ No ☐

If yes, what is being addressed? _____

Has there been any academic or psychological testing done at school or elsewhere? Yes ☐ No ☐

If yes: when and where? _____

Results:_____

_____

Have any of your child's biological relatives had any learning concerns:

_____

_____

Spirituality

Does your family have any past or current spiritual/religious beliefs, practices, or affiliations? Is your child involved with any religious activities?

_____

_____

Physical Health/Concerns

Describe any major health problems/surgeries/hospitalizations for any physical or emotional problem that your child has *had* or is *currently* being treated:

_____

_____

Does your child have any biological relatives that have physical health concerns?

_____

_____

What medications is your child currently taking (prescription/OTC/Supplements):

Name	Dose/Frequency	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If more space needed, please continue on back)

Do you have any nutritional concerns with your child? Yes ☐ No ☐

If yes, please explain:

_____

Name of Physician(s): _____

Recent/Present Physical Concerns (please check all of the symptoms below that apply to you):

☐ Stomach Aches	☐ Headaches	☐ Backaches	☐ Eating Difficulties
☐ Reproductive Concerns	☐ Grinding Teeth	☐ Sinus Problems	☐ G.I Issues
☐ Migraine Headaches	☐ Blackouts	☐ Cancer	☐ Sleep difficulties
☐ Decreased Energy	☐ Ulcers	☐ Chronic Pain	☐ Other: _____

Substance Use

Has your child ever tried: Tobacco ☐ Drugs ☐ Alcohol ☐

Do you suspect a problem with any substances? Yes ☐ No ☐

If so, please explain: _____

_____

_____

Emotional Concerns

Recent/Present Emotional Concerns (please check all of the symptoms below that apply to your child):

☐ Loss of Interest	☐ Difficulty Remembering	☐ Avoid Going Places
☐ Guilt	☐ Confusion	☐ Avoid Being With Others
☐ Concentration Difficulty	☐ Difficulty Making Decisions	☐ Checking Things Repeatedly
☐ Loss of Appetite	☐ Pornography	☐ Intense Fear
☐ Thoughts of Self-Harm	☐ Taking Risks	☐ Concerns with alcohol
☐ Thoughts of Harming Others	☐ Racing Thoughts	☐ Concerns with Drug Use
☐ Depression	☐ Hearing Voices	☐ Excessive Technology Use
☐ Feelings of Hopelessness	☐ Seeing Things	☐ Work Problems
☐ Episodes of Crying	☐ Anxiety	☐ Financial Problems
☐ Moody	☐ Panic Attacks	☐ Learning Problems
☐ Feeling Empty Inside	☐ Anger	☐ Relationship Problems
☐ Afraid of Rejection	☐ Worry	☐ Easily Irritated
☐ Sensory Concerns	☐ Other: _____	☐ Other: _____

Are there other concerns (not listed above) that you want to discuss?

_____

_____

Have any of your child's biological relatives ever had any psychiatric problems? Yes ☐ No ☐

Has your child had a history of trauma, abuse, or neglect? Yes ☐ No ☐

If yes, please explain: _____

If Yes, what types of abuse or trauma has he/she experienced?

☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal

☐ Natural Disaster ☐ Spiritual ☐ Domestic Violence ☐ Health

If other, please explain: _____

Has your child had any major losses in his/her life? Yes ☐ No ☐

If yes, please explain: _____

Major stressors in the past year: Yes ☐ No ☐

☐ Court System ☐ Family ☐ School ☐ Relationships ☐ Other

Please Explain: _____

_____

What are your child's personal strengths and/or hobbies?

_____

Has your child previously attended Counseling/Therapy (group or individual): Yes ☐ No ☐

Was it helpful? _____

Have you previously attended Counseling/Therapy (group or individual): Yes ☐ No ☐

Was it helpful? _____

Are you aware if there are any family members, relatives, or friends currently receiving counseling at New Leaf Resources? Yes ☐ No ☐

If so, who? _____

Whom can your child count on for **support/resources:**

_____

_____

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FORM #4.1

Consent & Agreement for Treatment - Minor

Client (Minor) Name _____ Date of Birth _____

(A separate form must be completed for each minor participating in treatment)

If I participate in sessions with my child's therapist, I am *required* to review and sign the Consent & Agreement for Treatment for Adults Form.

I, (parent/guardian) _____ do hereby authorize New Leaf Resources to provide counseling/treatment for (child) _____ as described on the adult consent form. I give this consent as the client's custodial parent or legal representative.

I understand that even if I do not participate in the treatment, the therapist is able to share with me the following information without authorization from the client:

- Current mental condition / status
- Diagnosis
- Treatment needs / recommendations
- Times and dates of service
- Billing / Insurance / Payment information

CLIENT'S BEING SEEN IN ILLINOIS:

- Client's under age 12: The parent or legal representative has the right to all treatment information.
- Client's ages 12—17: The parent or legal representative has the right to access only the information listed above, unless the client signs an authorization specifically releasing more information.
- Minors receiving services in Illinois who are age 12 or over are permitted to consent on their own behalf for up to 5 sessions, up to 45-minutes in length and may request that their parents not be notified of the service. Under these circumstances, the parent cannot be held liable for cost of services.

CLIENTS BEING SEEN IN INDIANA:

- Clients ages 0 –17: The parent or legal representative has the right to all treatment information
- Minors receiving services in Indiana are not able to consent to any sessions on their own behalf.
- I also understand I may revoke this consent at any time by giving written notice to the therapist.

_____ _____

Printed Name of Parent/Legal Guardian of Minor Client | Parent/Legal Guardian Date of Birth

_____ _____

Signature of Parent/Legal Guardian of Minor Client | Date

_____ _____

Signature of Witness | Date

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FORM #4.2

Consent & Agreement for Treatment - Parent/Legal Guardian

CONSENT TO COLLECT, CREATE, USE, MAINTAIN AND DISCLOSE YOUR HEALTH INFORMATION

(A separate form must be completed for each adult participating in treatment)

When we examine, diagnose, treat or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. This information may include your health records, health history, symptoms, examination and test results, diagnosis, treatment plans, and billing and health insurance information. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business (such as supervision) or required government functions (such as reporting abuse).

The New Leaf Resources (NLR) Privacy Practice Notice explains in more detail your rights and how we can use and share your information. The NLR Privacy Practice Notice is available online at www.newleafresources.org and available at each of the NLR offices by request.

Informed Consent

Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- Your condition or diagnosis
- The nature and purpose of treatment
- The likelihood of success
- The risks and potential consequences of treatment, including refusing treatment and the consequences of doing so
- The alternatives to treatment, including refusing treatment and the potential consequences of doing so
- The right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law

By Signing This Form, I Am Indicating

- I have read, understand and agree to the terms of the Consent & Agreement for Treatment as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have access to a copy of the NLR Privacy Practice Notice. NLR reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at NLR to provide me with treatment services.
- I understand that I have the right to request restrictions on the use or disclosure of my information. I understand that NLR is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. NLR has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment at any time.
- **If I do not sign this consent form, New Leaf Resources will not be able to treat me.**

Printed Name of Parent/Legal Guardian of Minor Client	Parent/Legal Guardian Date of Birth
Signature of Parent/Legal Guardian of Minor Client	Date
Signature of Witness	Date

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FORM #4.2

Consent & Agreement for Treatment - Parent/Legal Guardian

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(A separate form must be completed for each adult participating in treatment)

When we examine, diagnose, treat or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. This information may include your health records, health history, symptoms, examination and test results, diagnosis, treatment plans, and billing and health insurance information. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business (such as supervision) or required government functions (such as reporting abuse).

The New Leaf Resources (NLR) Privacy Practice Notice explains in more detail your rights and how we can use and share your information. The NLR Privacy Practice Notice is available online at www.newleafresources.org and available at each of the NLR offices by request.

Informed Consent

Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- Your condition or diagnosis
- The nature and purpose of treatment
- The likelihood of success
- The risks and potential consequences of treatment, including refusing treatment and the consequences of doing so
- The alternatives to treatment, including refusing treatment and the potential consequences of doing so
- The right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law

By Signing This Form, I Am Indicating

- I have read, understand and agree to the terms of the Consent & Agreement for Treatment as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have access to a copy of the NLR Privacy Practice Notice. NLR reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at NLR to provide me with treatment services.
- I understand that I have the right to request restrictions on the use or disclosure of my information. I understand that NLR is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. NLR has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment at any time.
- **If I do not sign this consent form, New Leaf Resources will not be able to treat me.**

Printed Name of Parent/Legal Guardian of Minor Client	Parent/Legal Guardian Date of Birth
Signature of Parent/Legal Guardian of Minor Client	Date
Signature of Witness	Date

Divorce/Separation Agreement

As the therapist you have chosen to work with your child(ren) during this difficult time, it is important to establish certain limits regarding the therapist's role in your and your child's life. The following limitations must be agreed upon as your child's therapist works with your child in order to enhance the therapeutic work and develop a positive, open relationship:

1. The role of your child's therapist is to create a therapeutic and safe environment for the sharing of feelings related to your divorce. It is understood that the therapist's neutrality in any post-divorce settlement dispute is for the benefit of your child.

2. Conflictual issues will not be addressed to the therapist for intervention. Any concerns regarding visitation or parenting may be presented to the child's representative, Guardian Ad Litem or your attorney. The therapist can provide you with interventions and strategies to enhance your child's mental and emotional health but will refrain from any comments regarding the other parent.

3. It is also understood that once therapy has commenced, your child's therapist **will not speak with either of your attorneys, nor will your child's therapist appear in court proceedings related to the divorce/custody settlement or visitation disputes.** Any information for such proceedings will be communicated by the child's representative or Guardian Ad Litem.

4. Therapy will terminate at a mutually agreed upon time or such earlier time as the therapist believes that the terms of this agreement are not being met and/or if the therapist believes that a continued therapeutic relationship would not be appropriate.

5. In the event that phone calls or reports related to the divorce are provided by the therapist, time spent on these activities will be billed at our normal hourly rate. Insurance does not pay for these services.

6. It is agreed that a condition of a New Leaf therapist treating your child is that with regard to any pending, contemplated or subsequent litigation regarding this child custody or visitation issues, both parents will and do hereby irrevocably stipulate that the child's therapist ***is and will be an incompetent witness***. It is understood that by executing this agreement the parties stipulate that the therapist cannot be called to testify with regard to any matters involving his or her therapeutic relationship with your child. It is further understood and agreed that should the therapist contact or be contacted with any courtroom issues (including where he or she is obligated to participate pursuant to the Abused and Neglected Child Reporting Act and/or Juvenile Court Act and communications with the child's representative or Guardian Ad Litem, custody evaluators or otherwise) and regardless of the circumstances, the parents shall

be individually and severally liable for the payment of fees at our current hourly rate for any time spent. It is also agreed that should your therapist hire an attorney to represent him or her with regard to any such matter or communications, that the parents be jointly and severally liable for all such attorney fees.

7. If either party, or the child's representative or Guardian Ad Litem attempts to secure the therapist's testimony at a deposition or otherwise and the therapist choose to be represented, and at the therapist's sole discretion, both parents shall be jointly and severally liable for all attorney's fees and costs incurred and the parents hereby agree to indemnify the therapist for any such fees and costs regardless of outcome including fees, expenses, or costs associated with any collections matters which may result from non-payment of fees.

8. It is understood that should there be pending a case involving the parents or guardians which in any way involves child custody or visitation an order must be entered incorporating this document as an agreed order by both parties.

This agreement must be signed by both parties involved in pending, contemplated, or subsequent litigation regarding child custody or visitation issues, and failure to meet or comply with any provision of this agreement shall result in the initiation of an immediate termination of therapy procedure and both parties agree to submit this agreement to their attorneys prior to initiating or resuming services with the therapist for their review and acceptance.

_____ _____

Signature of Father/Guardian Date

_____ _____

Signature of Mother/Guardian Date

_____ _____

Witness Date