V&R Behavioral Health Services 700 Ravinia Orland Park, IL 60462

p.708.226.0010 – f.708.226.0040

Reunification/Co-parenting Agreement, Office Policies & Procedures

We _____ and _____ agree to enter into Reunification and/or co-parenting therapy with Dr. Douglas Vaselakos per the court order. It is the responsibility of _____ to pay _____% of fees associated with this evaluation. If the Court Order does not specify a payment allocation, or if it only specifies the allocation of the retaining fees unless directed otherwise by the court or through agreement by both parties. INITIAL ____

A Court Order for services was ordered by Judge_____ on_____ INITIAL ____

Evaluation fees do not include charges incurred for copying the file, deposition or testimony unless otherwise ordered by the Court. A detailed explanation of those fees is contained below and will be the responsibility of the party requesting the evaluator's services unless otherwise specified by the Court. INITIAL ____

I understand that a credit card must be left on file, and that evaluation charges will be processed by V&R Behavioral Health Services consistent with the provisions contained in the credit card authorization form I have been asked to sign. INITIAL ____

Psychological tests and questionnaires included in the testing included in the testing are charged at a set rate for each item. Hourly charges do not apply for psychological testing, which is billed at $150.00 per hour. INITIAL ____

I understand that the main function of this service is to assist in rebuilding a parent/child relationship, to assist in co-parenting, improve communication, and to resolve identified differences/conflicts. I understand that the concern and love for my minor child/children must remain paramount and come before any differences, anger and conflicts. The therapist will assess all parties involved in this process. They will establish goals and objectives to guide the treatment process. The therapist will facilitate and create a therapeutic process in which difference can be resolved and conflict resolution can occur. Specific skill building in problem-solving, communication, and parenting will be developed. The process may include a combination of joint, individual and testing/evaluation sessions. No legal advice will be provided in this process. Legal questions will be redirected to each parties' attorneys and/or the court. INITIAL ____

Appointments will be scheduled with the therapist directly. If an appointment has to be rescheduled 24 hours in required to avoid being charged the full fee for the appointment. INITIAL ____

The Therapist cannot guarantee confidentiality of written and oral communications made by parties in the course of this work. Information provided by the parent(s), child, or any collaterals in the discussions with the therapist and/or in writing by the said individuals will be considered by the therapist when reporting progress to the Court, GAL and/or other counsel involved in the matter. INITIAL ____

Both parties involved in matter may communicate directly with the therapist separately. These communications are not confidential and maybe brought up in joint sessions. INITIAL ____

The parties agree to pay for the services which will include direct session time, time reviewing documents, correspondence and meetings with attorneys, medical professionals, GALs or any party related to the Court Order, collateral telephone, text and/or email conversations, reviewing deliberations, drafting letters, agreements, etc. We understand the fee for such services is $270 per initial meeting and $225 per hour after that, $150.00 per half hour, $75.00 per 15 minutes, and that fees are expected to be paid at the time they are provided. INITIAL ____

My signature below signifies that I have received the Office Policies & Procedures Agreement documents for V&R Behavioral Health Services and have been informed of the fees involved with this assessment and agree to be responsible for my pro-rata share of these fees. I also understand that fees are subject to change, and that re-engagement of this evaluator's services following the completion of the present report will be subject to the applicable fees at the time of re-engagement. Lastly, my signature indicates that I have given my informed consent to begin psychological treatment and have received the Notice of Privacy Practices form.

_____ _____

Signature Date

_____

Printed Name