

**Carol R. Hirshfield, Ph.D.**

*Clinical Psychologist*

**CA License: PSY 16827**

**WA License: PY 60909142**

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Phone: 310-560-7978 or 310-473-3200

*Los Angeles Office:*

10801 National Blvd., Suite 221

Los Angeles, CA 90064

*Seattle Office:*

1307 North 45<sup>th</sup> Street, Suite 200

Seattle, WA 98103

**CO-PARENTING THERAPY AGREEMENT**

This agreement is made between parents \_\_\_\_\_ and

\_\_\_\_\_, hereinafter referred to as “the parties” and the co-parenting therapist/mediator, Dr. Carol Hirshfield. This includes therapy, parent education and mediation of parenting disputes.

**I. ISSUES OF CONCERN**

The parties and/or the Court specify the following issues of concern that are to be addressed in the co-parenting therapy:

a) Emotional/Behavioral Problems of the child/children:

b) Problems between parents and child/children:

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c) Communication, co-parenting difficulties:

d) Coaching on parenting skills needed:

e) Other issues, specify:

### **II. Confidentiality, privilege and reports to the Court**

This therapy (check one) \_\_\_ shall \_\_\_ shall not include a report to the Court, as specified in the order or stipulated agreement dated \_\_\_\_\_ (attached). The report can include dates attended, progress made by each parent, but will not include recommendations regarding custody, visitation, or other issues which might be considered a custody or parenting plan evaluation.

If this therapy includes a report, then the therapy is not privileged or confidential. All communication made during the sessions can be reported to the Court.

If therapy is confidential, then release of any communication from sessions must be with written authorization by both parties.

**NO VIDEO OR AUDIO RECORDINGS ARE ALLOWED DURING SESSIONS.**

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### III. **Communication with attorneys, other therapists and access to files**

Dr. Carol Hirshfield (check one) \_\_\_ may \_\_\_ may not communicate in a simultaneous conference call with attorneys regarding this case. Such communication shall occur only with both attorneys and with the written consent of both parties. If there is minors' counsel, and that attorney has authority to do so, they can also be part of the communication.

Dr. Carol Hirshfield (check one) \_\_\_ may \_\_\_ may not have access to custody/parenting evaluations, court filings or other documents that the Court or the parties agree to send to this Psychologist.

Dr. Carol Hirshfield (check one) \_\_\_ may or \_\_\_ may not communicate with a family therapist or a therapist for an individual family member. These are the providers who are included:

Written authorization for all of the above is to be provided to Dr. Hirshfield by the parties.

### IV. **Professional fees**

All services are paid at the rate of \$300 per hour, including all sessions with each party and for both parties, review of files, emails, conference calls with attorneys, reports to the Court or other correspondence. The cost of this service is to be paid by:

\_\_\_\_\_ for % and \_\_\_\_\_ for %.

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Please arrange for a deposit of \$1200, to be held on account. This deposit can be paid by Zelle ([drcarol@drcarolhirshfield.com](mailto:drcarol@drcarolhirshfield.com) ) All other sessions to be paid at the time of service.

Cancellation of all session must be made no later than 48 hours in advance. For sessions scheduled for Mondays, such cancellation needs to be made by Thursday of the prior week. Session cancelled later than 48 hours In advance will be charged to the parties in full.

I am signing my agreement to all terms outlined above and will abide by them.

Dated:           Signature:

Print Name:

Dated:           Signature:

Print Name: