# PARENT-CHILD REUNIFICATION THERAPY
# POLICIES, PROCEDURES AND PATIENT CONSENT

**Parent-child Reunification Therapy**

Reunification therapy is to restore a relationship between a parent and child who are estranged and not participating in scheduled parent-time. It is not a health care service; it is not treating a diagnosable condition, and cannot be billed to health care insurance. The purpose of reunification therapy is to discuss and resolve the conflicts or disputes that underlie the estrangement so that regular visits and a healthy parent-child relationship can be restored.

Reunification therapy can have benefits and risks. Estrangement is a strategy of avoidance, and reunification requires resolving problems without avoidance. It requires meetings where conflicts are discussed, and can be uncomfortable. The consequences of allowing parental estrangement to persist are well documented in research and include a loss of family and emotional support, loss of financial support, and the development of relationship skills that are associated with poor adult relationship functioning. Successful parent-child reunification restores the severed relationship and relieves the problems associated with estrangement.

**Meetings**

I typically begin by collecting background information about the estrangement. I do this by meeting separately with the estranged parent, the other parent, and the estranged children. Then, visits are scheduled for me to meet with the children and the estranged parent. These meetings will recur weekly until regular parent-time is restored and all parties are satisfied with the quality of the shared time.

Once an appointment is scheduled, you will be expected to pay for it unless you provide at least 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control.

**Contacting me**

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail where you can leave a confidential message. If you are difficult to reach, please inform me of some times when you will be available. In the event of a mental health crisis, call the University Neuropsychiatric Institute Crisis Line at (801) 587-3000 or call 911.

Email communication is a convenient means for scheduling appointments and exchanging other information that is not sensitive. Email is not secure as messages are stored on remote servers, and though I have never heard of this happening, it is advisable to avoid using regular email to send any information you would not want to reveal in public. Upon request via regular email, I will send you a link to send me an encrypted, secure email.

**Confidentiality**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form. There

are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

It is often necessary to talk to the non-estranged parent in the course of reunification therapy. Your agreement for such contact is required for participating in reunification therapy, and understood by your consent below.

If attorneys or the court are involved, I will need to communicate with them, at my discretion.
I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of the parties. The other professionals are also legally bound to keep the information confidential. I will not notify you about these anonymous consultations unless I feel that it is important to our work together.

You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share confidential information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.

I also have formal business associate contracts with Bonneville Collections (for collecting on delinquent accounts). These contracts require Bonneville Collections to maintain the confidentiality of these data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a model copy of my business associate contract.

**There are some situations where I am permitted or required to disclose information without either your consent or Authorization:**

If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the appropriate parties, the patient's employer, the workers' compensation insurance carrier or the Labor Commission.

**There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are uncommon in my practice.**

Child Abuse: If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

Abuse of Vulnerable Adult: If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.

Harm to others: If a patient communicates an actual threat of physical violence against an identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.

Communicable Disease: If I have reason to believe that you are suspected of having or are suffering from a disease that is communicable, I am required by law to report this to the local health department.

**Minors and Parents**

Reunification therapy usually involves minor children. Consent for their participation is given by the parent, and it is understood that they often would not consent to participate if they were asked. It is common in court-involved cases for the non-estranged parent to be required to see that the minor children attend scheduled meetings.

**Professional Fees**

My fee for a 55-minute session in a reunification case is $165[1]. In addition to appointments, I charge this prorated amount for other professional services you may need. Other services could include letter or report writing, telephone conversations with a party or on behalf of the case, consulting with other involved professionals, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you agree to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $225 per hour for preparation and attendance at any legal proceeding, payment due with the request to appear.

**Insurance Reimbursement**

Reunification is not a health care service and I won't bill these services to a health care plan nor accept a health care plan's allowable fees.

**Billing and Payments**

I require payment at the time of service. I accept cash, check, MasterCard, Visa, Discover and American Express. **I require a credit card on file to guarantee payment.** Your credit card will be charged for amounts not paid at the time of service. If both parents are splitting the costs, I will need a credit card authorization on file for each party. If a payment is not made or a credit card charge is declined, I may suspend my services. I will accept payment on behalf of a delinquent party from any source (including the other parent) to continue services. I will account for the source of payments but will not collect payments for a delinquent party if payment is made by another party.

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1My fees change infrequently, usually every few years, and by a small percentage, but as you may be a patient for many years, this will keep fees the same for all patients. When fees change on my website, they will change on your account. My current fees can be found on the consent forms for Reunification Therapy services at www.chriswehl.com/forms.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, this signed contract, and a statement of charges and payments. If such legal action or collections agency is necessary, you will be charged a collection fee of up to 50%, plus any attorney's fees, court costs, and filing fees. You will be charged interest of 1.5% per month on any balance over 30 days that is owed. You will be assessed a $15 statement fee for any month with no billable activity and an unpaid balance. You will be charged my bank fee plus $10 (currently $45) for checks returned unpaid by your bank. Scheduled appointments not cancelled at least 24 hour in advance will be charged to you (full fee at Dr. Wehl's discretion). Any refunds on funds paid via credit cards will have the credit card fees deducted from the refunded amount (currently 3%).

**I have read and understand the procedures for emergencies, confidentiality, billing, payment, and I consent to treatment for myself and child(ren) under the conditions described. I agree to the above described terms regarding interest, collections charges, charges for appointments missed or cancelled late, fees for checks returned unpaid, and payment of costs of collecting delinquent accounts.**

**Required credit card to be used to bring my account current if I do not pay by another means at the time of service. I also authorize Dr. Wehl to validate this card by making a nominal charge which will be credited to my account.**

**Visa Mastercard Amex # _____ Exp: _____**
**card number**

**3 or 4 digit Card Security Code_____ Billing zip code for card: _____**

**Circle one**

**Yes No Do you want us to bill your credit card periodically for the amount you owe? This is the best way to keep your case progressing, as I have to stop working on your case from when I send statements until I receive payment. If you check this option I will send you an itemized statement.**

**Yes No Do you want to receive statements by email?**

**I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY ITS TERMS.**

_____ _____
Client Signature Date

_____ _____
Legal Guardian Date
(if client is a minor)

_____ _____
Financially Responsible Party Date
(if different)

**ESTRANGED PARENT**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____ Email:_____

Sex:( M : F ) Date of Birth: _____ Age: _____

**ESTRANGED CHILD 1**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____ Email:_____

Sex:( M : F ) Date of Birth: _____ Age: _____

**ESTRANGED CHILD 2**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____ Email:_____

Sex:( M : F ) Date of Birth: _____ Age: _____

**RESPONSIBLE PARTY IF DIFFERENT THAN ESTRANGED Parent (Statements will be sent to)**
This must be the person signing fee agreement as responsible party

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____

Email:_____