

Comprehensive Counseling Connections, PLLC

Separated / Divorced Parents' Agreement Form

I, _____, _____ of _____
Name of Parent Relationship to Child Name of Child

hearby authorize Counseling Connections, PLLC and any of its providers to provide Outpatient Mental Health Services for my child.

I understand that CCC's primary responsibility is my child's best interest, and that his/her provider may involve me in my child's treatment/evaluation. I understand that if payment is not received promptly for services rendered by CCC to my child, the services may be suspended and/or billed to all responsible parties.

I understand that my child's clinical provider is not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than my child at any deposition, court proceeding, or in any other way. I understand that my child's clinical provider may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding, at their sole discretion. CCC will charge for the receipt of any correspondence or acceptance of any telephone calls, including those directly from the court or counsel for my child. The charge will be \$100 an hour (billable units will be in 15-minute increments) and is not covered by insurance.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Name of Parent

Date

Name of Parent

Date

Comprehensive Counseling Connections • 187 North State Street • Concord NH 03301

 (603) 856-8163  (603) 856-8164