**MORNINGSTAR COUNSELING, LLC**
**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Name: _____ Date of Birth: _____**

## Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

## Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ **I hereby authorize Morning Star Counseling to RELEASE my protected health information (PHI) to:**

_____

☐ **I hereby authorize Morning Star Counseling to OBTAIN my protected health information (PHI) from:**

_____

### Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

☐ Face sheet
☐ Laboratory/diagnostic testing results
☐ Discharge summary
☐ Behavioral health/psychological consult
☐ ER record report
☐ Substance abuse treatment records
☐ Progress & Case Notes
☐ Psychological evaluation/testing results
☐ History & physical
☐ School information
☐ Medication records
☐ Psychosocial assessment/Family history
☐ Psychiatric evaluation
☐ HIV/AIDS lab results & treatment history
☐ Summary of treatment records & contact dates
X Other: diagnosis, treatment plan, for **billing purposes**
☐ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by *_____*, Inc. without my written consent. I understand that this authorization will remain in effect for:

X The period necessary to complete all transactions on accounts related to services provided to me.
☐ One (1) year
☐ Other:_____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

*Signature of Client/Legal Guardian or Legally Authorized Representative* *Date*

_____ _____

*Witness* *Date*

**Morning Star Counseling, LLC**
200 South Church Street
Quarryville, PA 17566

# Consent to Treatment

## THERAPEUTIC PROCESS

You have decided to embark on a powerful journey known as therapy, a decision of strength and courage. Know that Morning Star Counseling (MSC) considers the therapeutic relationship to be one of sacred trust. This letter serves to inform you about the therapeutic process, give you some information and answer questions about the professional relationship between therapist and clients.

Therapy cannot ensure the successful resolution of the issues you bring to it. Human beings are far too complex and life is too uncertain. However, it is our experience that most people can gain some value from the therapeutic process. Know that as we journey together new, often unforeseen destinations may appear. The therapeutic process may not only affect you, but also relationships, work and other areas of life. There are alternatives and many adjuncts to therapy. These include, but are not limited to, medications, support groups and complimentary modalities. I will be happy to discuss any alternatives you want to consider at any time.

There are likely many different approaches to addressing your treatment needs. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for it to be successful, you will have to work on things we talk about both during our sessions and at home. For instance, you may be asked to read a book, chart moods or behaviors, journal, or practice strategies discussed at home between sessions. You are expected to play an active role in the therapeutic process. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there is no guarantee. Therapy can be short-term, focusing on one specific issue or concern, or longer-term if the issues are more complex. The more motivated you are to change your situation and the more effort you put into the process, the better the chance of success.

Our first couple sessions will include an assessment, which involves gathering information about your past and present medical, social, and psychological wellbeing. This includes an evaluation of your current needs. By the end of the evaluation, your therapist will decide if he/she is able to address your needs and you can decide whether or not you are comfortable with him/her and feel as though he/she is a good fit for you. Your therapist will then be able to offer you some first impressions of what our work will include and he/she will develop a treatment plan with you, if you decide to continue with therapy. If it is determined that your needs are outside of our area of expertise, we will be happy to refer you to another professional as it is most important to me that you find help from the person best suited to address your needs.

## BILLING AND PAYMENTS

Our current fee is **$200/$100** per session. The assessment fee is the same as our standard hourly rate for that time of day for clients who are self-pay. Therapy sessions are 55 minutes in length and will typically be scheduled either weekly or biweekly at a time that we both agree upon. Payment for your session is due **at the time of service**. MSC accepts cash, personal checks, and credit cards. We work with some insurance companies via managed care contracts and we will file claims for your services. You must pay your copay at the time services are rendered. Even if we are not a participating provider in your insurance company's network, your insurance company may reimburse you for a portion of your fee for services rendered. You will need to check with your insurance company ahead of time to inquire about whether or not they will reimburse you for services by an out of network provider. You are still required to pay for your session at the time of service.

If you need to cancel an appointment for any reason, you will be expected to notify MSC at least 24 hours in advance to avoid a cancellation fee of $50. **Insurances cannot be billed for missed or late cancellation appointments**. Any fees assessed must be paid on or before your next scheduled appointment.

In addition to therapeutic session fees, we charge for other professional services you may need including report writing, telephone conversations lasting longer than 10 minutes, attendance at meeting with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other services you may request of us. Our charge is $100/hour for each of those services. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $200 per hour for preparation and attendance at any legal proceeding, including travel time, and travel expenses.

If you have an outstanding balance for therapy session fees or other professional services in excess of 60 days past due and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. **Customer agrees to be responsible for all costs of collection on unpaid balances including, but not limited to, 1 ½% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.**

## CONTACT

We are often not immediately available by telephone. While we are in the office most days during business hours, we cannot always answer the phone when we are seeing clients. When we are unavailable, our telephone will be answered by voice mail and you can leave a message for us to return your call. Your therapist will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are in an emergency situation, dial 911 for assistance or go immediately to your local emergency department.

Morning Star Counseling uses a basic (unsecured) email system. With your verbal permission, we will obtain your email address to use for appointment reminders. Your signature below indicates that you are aware of the lack of security of the email system. If you chose to email us for any reason we cannot guarantee the confidentiality of your email. If you are giving us your email address, then you are acknowledging that you are aware of the insecurity of our system and give us permission to email you anyway. Similarly, some clients prefer to communicate via text messaging to our cell phones in lieu of contacting the office. If you chose to communicate with us via text messages, you are acknowledging the risks of jeopardizing your confidentiality when doing so.

## PROFESSIONAL RECORDS

The laws and standards of my profession require that we keep treatment records. You are entitled to receive a copy of your records, or we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained reader. If you wish to see your records, I recommend that you review them in the presence of your therapist so that he/she can discuss the contents with you.

**MINORS**

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. If you are 16 or 17 years of age, it is our policy to request an agreement from your parents asking them to agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of any concern. Before giving them any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have about what we are prepared to discuss.

**CONFIDENTIALITY**

In general, the law protects the privacy of all communications between a client and a mental health professional, and we can release information about our work to others only with your written permission. There are just a few exceptions to your rights of confidentiality.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. Those exceptions are the following: 1. If we believe that a child is being abused, we must file a report with the appropriate state agency. 2. We are also required to make a report if a client is threatening bodily harm to another individual. In this case, we are required to inform the police as well as the intended victim. 3. If a client threatens to harm him or herself, we may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. In this case, we will do whatever we can to enlist the client's cooperation first to ensure his/her safety.

During the course in treatment, we may occasionally find it helpful to consult with other professionals about a case. During such consultation, we make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential.

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in our office. If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact; this allows you to maintain the privacy of your therapeutic relationship. Please do not invite your therapist to social gatherings (including, but not limited to, parties, weddings, business meetings, etc.), offer gifts, or ask them to relate to you in any way other than the professional context of our therapy sessions. Although this may seem artificial and/or awkward, it is the best way to promote a good therapeutic relationship.

**CONSENT**

Your signature below indicates that you have read the information in this document and agree to abide by its terms, including the following:

I do hereby seek and consent to take part in the treatment provided by this agency. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I (or my child) may stop treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party may be given information about the type (s), cost (s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

_____ _____

**Signature of Client (or person acting for client)** **Date**

_____

**Relationship to Client**

We have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

**Signature of Representative of Morning Star** **Date**

**Client Name** _____

# *Morning Star Counseling*

## Policies and Practices to Protect the Privacy of Your Health Information

**HIPAA and CONFIDENTIALITY INFORMATION**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

**Effective/Last Revised Date: March 21, 2020**

*Consultation and Counseling* is required by federal law to protect the privacy of your health information in the context of your mental health and substance abuse health care administered by this agency. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it in our agency office or on the website.

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
  - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- Where required by law.

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization**

**We have the right** to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **To process** claims for health care services you receive.
- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your general health.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Referral Sources.** If you are referred through another agency such as your Primary Care Physician, Juvenile Court, DFCS, Psychiatric Hospital, CMHC, etc., we may share summary information and admission and discharge information with the referral source. In addition, we may share other health information with the referral source for case management purposes if the referral source agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical or mental health care to you.

**We may** use or disclose PHI ***without your consent*** or authorization in the following circumstances under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including social service or protective service agencies. If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority. If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations. If we are the subject of an inquiry by the Georgia Composite Board, we may be required to disclose protected health information regarding you in proceedings before the Board.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena. If you arc involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent, subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **Serious Threat to Health or Safety.** If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws relating to job-related injuries. We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

If none of the above reasons applies, **then we will obtain your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you have given us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based upon your authorization. To revoke an authorization, contact the phone number listed below on this notice.

**HIGHLY CONFIDENTIAL INFORMATION**
Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

**IV. Patient's Rights and Therapist's Duties**

**Patient's Rights:**

- *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.
- *Right to Amend*— You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

**Therapist's Duties:**

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise these policies and procedures, we will notify you by mail or on your next session. You may obtain a copy of this notice at the local office or website.

**V.** Complaints

- Contacting Morning Star Counseling, LLC. If you have any questions about this notice or want to exercise any of your rights, please call 845-473-4939. Please specify that your question or concern is in reference to your mental health and/or substance abuse protected health information.
- Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the following address: 200 South Church Street, Quarryville, PA 17566

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at www.hhs.gov. **We will not take any adverse action against you for filing a complaint.**

**VI. Cancellation Policy**

In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by clinic staff at least 24 hours prior to the scheduled session will be billed at the session rate. Your insurance company will not pay for missed appointments.

**VII. Financial Responsibility**

**Morning Star Counseling, LLC** may assist you in completing and filing any insurance forms, which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services and you will need to update any changed insurance information immediately upon the date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered. Morning Star Counseling does accept payment by cash, check or credit card.

**VIII. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on October 1, 2006. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.

**IX. Patient's Consent**

I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read this statement of Morning Star Counseling's practices and policies and I both understand and approve of its content.

_____
Printed Name of Client

_____
Signature of Client and/or Guardian

_____
Witness

_____
Date

## CREDIT/DEBIT CARD RELEASE

In order to maintain efficiency for both our practice and our clients, we are offering the option of keeping your credit/debit card information in your secure electronic file to use for service fees and/or copays as services are rendered. Doing so will provide the convenience for our clients in not having to pay our staff during visits and allow you to maximize your time with your therapist, particularly when being seen in the evenings or during office hours in which an administrative assistant may not be present to collect fees before or after your session. In addition, it will allow us to maintain efficiency in collecting payments from clients after services are rendered for uncollected fees or fees not paid by your health insurance. This is simply an option, not a requirement. If you have any questions, do not hesitate to ask. Completing the information and signing below will indicate your consent to allow Morning Star Counseling to charge your account for services rendered. This will not compromise your ability to dispute a charge. Please give our office a call if you prefer to give this info over the phone.

Client Name (print): _____

Name on Card: _____ Circle One: Visa / Mastercard / Discover / American Express

Card #: _____ Exp. Date: _____

Please print email address if a receipt is desired for each transaction:

Email: _____

I hereby give my consent to Morning Star Counseling, LLC to charge my credit/debit card:

_____ _____

Cardholder Signature Date

---

## CANCELLATION POLICY

If you must cancel an appointment, please give 24 hours notice by leaving a message in our g**eneral administrative voice mail** at 717/806-5050. Forgotten appointments or cancellations after the 24 hour window will be charged $50 regardless of the reason. We understand that on occasion circumstances (transportation issues, illness, childcare, etc.) arise, so in those instances the $50 fee will cover some of our time and we will not hold you responsible for the full counseling session fee. Unlike medical doctors who often see 30 or more patients a day, we reserve an entire hour out of our day for your treatment. Please note that insurance does not cover canceled appointments. If circumstances such as transportation or childcare arrive, please consider the option of a phone or VideoTherapy session, which we are often able to accommodate.

The decision to hold sessions under inclement weather conditions will be made mutually between the therapist and the client. In such cases, we are often able to do phone or VideoTherapy sessions as well.

_____ _____

Client Signature Date

_____ _____

Witness Date

**Save this as a PDF, and email to admin@morningstarllc.org. Please call our office with questions at 717/806-5050.**

MORNING STAR
COUNSELING

*200 S. Church Street, Quarryville PA 17566*
*(717) 806-5050 www.morningstarllc.org*

# Co-Parenting Contract

Both co-parents will understand that this form of therapy is based on education, problem-solving, and skill building. You will receive a workbook with the relevant materials that should be brought to every session.

Both co-parents will be committed to openness and honesty throughout this process, keeping the child/childrens' best interests in mind.

Co-parents will recognize that divorce – especially when coupled with extended disputes, hostility between co-parents, and ongoing litigation - stretches a child's coping resources beyond his or her capacity. Throughout the divorce and its aftermath, the child has had little control over the major upheavals that dramatically, negatively, and permanently alter his or her life.

Co-parents will understand that discussion regarding current or past litigation will not be tolerated as it does not relate to the psychoeducational service being provided. If this occurs, the therapist will reframe the discussion and has the discretion to end the session with the offending parent or both parents.

**Strong emotions make it difficult for co-parents to understand what is best for the child**. It is up to the co-parents to establish and maintain a healthy environment that does not have parents on opposite "sides."

No "mind-reading," that is presuming to know the intentions, motivations, thoughts, feelings of your co-parent, or "crystal ball reading," that is predicting how your partner will behave in the future, will be tolerated.

The parties will accept my direction and re-direction during sessions. No defensiveness, disdain, self-centered diatribes, arguing, blame, accusations, or hostility will be tolerated. If one party begins to exhibit these behaviors, he or she will be asked to be quiet until they can participate productively. If

that person repeats the problem behavior, he or she will be asked to go to the waiting room for several minutes and then we will try to resume productive discussion. If the problem occurs a third time during the same session, we will terminate the session and try again the following appointment.

The therapist will be respectful but direct in cutting off unhealthy verbal and non-verbal communication between co-parents. This includes behaviors such as rolling one's eyes, interrupting, or any utterances and facial expressions that convey disdain or disengagement. The co-parents will learn to consider, before speaking, whether their words will move the process forward or backward.

From here forward, no co-parent shall ever say to the child/children anything disparaging, dismissive, rude, or hateful about the other co-parent. Should the therapist find out that this behavior is occurring, it can be grounds for termination of services.

When discussing current problems, co-parents often want to dwell in the past. They falsely believe that it is important for the therapist to know how treacherous, deceitful, hostile, abusive, resistant to change, or harassing the other co-parent has been. Due to this, the therapist may suggest (and at times, require) co-parents to have individual counseling to address their own past experiences with their co-parent. Co-parenting is not intended as a form of individual therapy and can hinder progress in being able to promote a healthy relationship between the child and both parents.

CONSENT: Your signature below indicates that you have read the information in this document and agree to abide by its terms.

_____ _____

Signature of Co-Parent Date:

_____ _____

Signature of Co-Parent Date:

_____ _____

Signature of Morning Star Counseling Representative Date: