



Loretta Maase, M.A. LPC, NCC

PARENTING SERVICES INFORMATION SHEET

FILL IN YOUR INFORMATION ONLY

Court cause no _____ Judge ordering _____ County _____
Marriage date _____ Date of separation _____ / divorce _____
Date ordered _____ Next scheduled hearing date _____

MOTHER:
Name _____
Address _____
Phone [H] _____ [W] _____
Fax _____ Cell _____
Email _____

FATHER:
Name _____
Address _____
Phone [H] _____ [W] _____
Fax _____ Cell _____
Email _____

MOTHER'S Attorney:
Name _____
Address _____
Phone _____ Fax _____
Email _____

Father's Attorney:
Name _____
Address _____
Phone _____ Fax _____
Email _____

CHILD/REN:
Name _____ Date of birth _____ With whom primarily residing _____

CHILD/REN's Attorney/s:
Name _____
Address _____
Phone _____ Fax _____

OTHER PARTY:
Name _____
Address _____
Phone _____ Fax _____

LEGAL DECISIONS PENDING: ___ Pre-divorce OR ___ Post-divorce OR ___ Never married
Dissolution of marriage _____
Spousal maintenance: _____
Property settlement: _____
Child support: _____
Conservatorship: _____
Parent to establish primary residence: _____
Parental access: _____
Relocation: _____
Modification: _____
Enforcement: _____

Is a Protective Order in place: ___ yes ___ no

Send to: Loretta Maase, M.A., P.O. Box 90874 Austin, Texas 78709-0874

Therapy/Coaching Contract

The circumstances that lead co-parents to seek intervention are quite varied. Some are compelled to attend services while others enter the relationship with a clearly defined intent. My role as your parenting coach will be to facilitate an exploratory process enabling you and your co-parent to evaluate your current situation, recognize your strengths, and help you discover what is preventing you from using those strengths to become the co-parent/parent you want to be. This process involves a thorough examination of your current state of affairs. The therapeutic/coaching process involves distinctive working stages from the initial session to the conclusion and termination of services, each of which contains therapeutic value.

As your therapist/coach, I will play a supportive role in guiding you through the progression of each stage. You can expect an atmosphere of respect at all times. You should know that I view the counseling/coaching relationship as a collaborative effort between the client and counselor. Therapeutic gains do not typically arise spontaneously, nor will your circumstances improve without a genuine effort on your part. As a client, it is within your right to participate in the process of setting goals and planning your therapeutic/coaching treatment. If for any reason I am unable to meet your needs as a therapist and/or coach, I will provide referrals to other qualified practitioners in the local area.

My counseling/coaching style is comprised of techniques from various theoretical perspectives and includes an educational component intended to impart knowledge and skills that will ultimately enable you to proceed independently with confidence. I will also guide you through mediated conversations/negotiations with the intention of you eventually handling the negotiation process on your own as co-parents, if appropriate. The length of time required to accomplish such a goal will depend on the specific nature and complexity of the issues surrounding your unique situation.

Although the therapeutic/coaching relationship involves an intimate connection between the client and counselor, it is imperative that our relationship remains purely professional in nature. All of our sessions will become a part of your clinical record. As such, the information you share with me is considered confidential and may not be disclosed without your express written consent. Certain exceptions do exist. As your counselor/coach, I am legally bound to take action and / or make disclosures any time it is deemed necessary for the protection of life. Additionally, disclosure of counseling/coaching information will be required in situations in which: (1) you authorize me to inform someone else (as in the case of insurance reimbursement or consultation with another professional), (2) I am ordered by a court of law to disclose your information, (3) I determine that you are a danger to yourself or others, (4) I become aware that there is neglect or abuse (whether physical or sexual) involving a child or an aged adult.

I may engage in periodic staffing or consultation with other counseling professionals about client related issues as a means of providing better services to clients. Nonetheless, specific information revealing client identity will remain in confidence according to the limits of confidentiality outlined above.

Parents / Guardians: If you are seeking services for a child or adolescent, as a parent, you will be asked to participate in the therapeutic process in one or more ways: (i.e., an overall supportive way includes both financial and physical support). If parents do not live in the same household, I ask that parents cooperate in alternating bringing the child(ren) to therapy. You may also be asked to participate in family sessions. You should know that it is within your rights, as parents or legal guardians of minor children (under the age of 17), to request information concerning your child's progress and treatment in individual sessions. However, it is often harmful to the therapeutic process if I am not able to assure your child that our work will remain confidential. I believe that therapy is only beneficial if it provides a safe environment in which clients can openly explore their own value system and examine their choices and behaviors in a non-judgmental context. To this end, I will not be sharing with you everything that your child talks about in therapy. As parents / guardians, I ask that you agree not to ask specific questions concerning the detail or content of information disclosed during individual sessions with your child. In turn, I agree to work collaboratively with him/her in an effort to provide you with general updates when requested and will disclose information to you in preservation of the therapeutic relationship. Trust that I will let you know if I do not think your child is benefiting from therapy.

Fees are considered part of your therapy: You are responsible for payment of your fee (made payable to ParentRise) by cash, personal check, or debit/credit card at the time of service. For parents seeking services for their child(ren), whichever parent brings the child(ren) is responsible for payment at the time of service. The only exception to this is when there is an agreement in writing designating a "responsible party" for payment (as is the case in some divorcing / divorced families through some legal avenue such as a court order, Rule 11 Agreement or MSA).

Current fees are outlined as follows:

- \$135 for an initial session (typically 80 minutes in duration)
- \$90 for 50-minute individual sessions (beyond the initial session)
- \$135 for 80-minute couple, family, or co-parent sessions (beyond the initial session)
- \$50 for group sessions of 80-minute duration
- \$1,000 retainer for Parent Coordinator / Parent Facilitator (typically split between parents)
- \$100 per hour for court testimony + \$150 per hour preparation time, prorated by quarter hour entered
- \$100 per page for written reports
- \$90 per hour for consultation w/ other professionals, billed by the quarter hour entered
- \$90 missed session fee (includes cancelled appointments with less than 24-hours' notice)
- \$45 returned check fee
- If paying by credit card I add \$2.50 to the fee for service charges. I apologize in advance for this, but service fees add up.
- I request that I keep credit card information on file, even if you pay by check.

If you arrive late for your scheduled session, that session will be shortened by the amount of time that you are late. In the event that you are unable to keep a scheduled appointment, you will be required to provide a minimum 24-hour advanced notification. Failure to do so will result in a \$90 cancellation fee that must be paid prior to your next regularly scheduled appointment. You are required to provide credit or debit card information for the purpose of charging fees for missed appointments or cancellations with less than 24-hour notice.

Please provide the appropriate information in the space below and know that your information will be maintained in confidence and used solely for the purpose of charging missed session / cancellation fees.

Visa Master Card Disc # _____ Exp. ____ / ____

Three digit code: _____ Zip Code _____

Name on Card _____ Signature _____

Frequent cancellations indicate a need to address the issue during the therapy session; therefore, you should be prepared to do so. Returned checks are subject to an additional fee of \$45. If your check is returned, you will be required to make any future payments by cash or money order. After-hours calls, emergencies, or out of the office therapy will be billed at the rate of your regular fee plus 25%, billed by the quarter hour. This includes travel time and phone calls in excess of ten minutes. ***Phone calls made during regular office hours in excess of ten minutes will be billed at my full fee.*** Note, this does not apply to calls for scheduling or administrative purposes. There is no charge for calls lasting less than ten minutes.

Termination of coaching/therapy is ordinarily a planned event. However, in some cases, immediate termination of services may be necessary. Examples of these cases are non-payment for services, threatening or abusive behavior, or consistently cancelled or missed appointments.

In the event of an emergency you may contact me at (512) 897-8777. If I am unavailable and your situation requires immediate attention, please contact your local police department or go directly to the nearest emergency room. You may also call the Crisis Hotline at (512) 472-4357. There will likely be times when I am away from my office due to training, vacation, or family obligations. During these times I will provide you with ample notification of my absence and how to contact me if needed. If for any reason I am abruptly unable to provide service due to some unforeseen emergency, my files will be maintained by Arielle Maase, my office assistant.

I am a Licensed Professional Counselor (LPC), a Nationally Certified Counselor (NCC), and hold a Master of Arts degree in counseling from Webster University, with a specialization in child development, parent education, co-parent therapy, and psychotherapy. I have worked with low-to high conflict co-parents in New Mexico and Texas as a parenting coach since the mid 1990's. Additionally, I have the following specializations/certifications: Certified Trauma Therapist, Certified Dialectical Behavior Therapist, Parenting Facilitator/Coordinator, National Trainer with the Nurturing Parenting Program (train therapists/teachers on Nurturing Program), Credentialed Family Law Mediator, and Collaborative Law Mental Health Professional.

If at any time you are dissatisfied with my services, I encourage you to discuss your concerns with me directly. If for any reason we are unable to resolve the situation to your satisfaction, you may file a complaint with the Texas State Board of Examiners of Professional Counselors at (512) 834-6658 / (800) 942-5540.

This document is constructed for the purpose of informing you about your rights as a client. If at any time, questions or concerns arise about any aspect of therapy, I welcome and encourage you to discuss them with me directly.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMATION CONTAINED IN THIS CONTRACT. ANY QUESTIONS I MAY HAVE HAD ABOUT THIS STATEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. I FURTHERMORE AGREE TO RELEASE TAMMY L. CORRALES FROM ANY AND ALL LIABILITIES.

Client Signature		Date
------------------	--	------

Client Signature		Date
------------------	--	------

Parent or Legal Guardian Signature (if client is a minor)		Date
--	--	------

Loretta Maase, M.A., LPC, NCC		Date
-------------------------------	--	------



Loretta Maase, M.A., LPC, NCC

AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORDS OR INFORMATION

ParentRise Nurturing Program

Ph 512-897-8777; fax 512-584-8106

www.parentrise.com; lorettamaase@parentrise.com

I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization by writing the word "Revoke," my signature, and the date across this form at any time after signed, except to the extent that action has been taken in reliance on it. I also understand that permission to release family records must come from all members of the family age 18 or over participating in the services, or information released must be restricted only to information regarding the person/s who signs the release on behalf of her/himself or a minor child of whom they have legal rights to consent for treatment. If not previously revoked, this authorization will automatically expire one year following completion of services with this provider.

I authorize the parenting coach, Loretta Maase, M.A., LPC

To disclose information to: AND/OR To obtain information from:

All attorneys involved in this case, as identified by court records

My attorney: My therapist: My child/ren's therapist: Other (GAL):

Client name [please print] signature date