Several of the following questions require disclosure of sensitive information. This information is required for identification to staff and police and so that the therapist understands any circumstances that may affect your children during visitation. Your honest disclosure is crucial to our ability to provide safe and effective service to your family. If you have any questions or concerns about any of the information requested please notify the therapist who processes your intake or feel free to call the office at any time.

### Parent/Guardian Information

**Personal Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
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<tr>
<td>Last Name:</td>
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<tr>
<td>Street Address:</td>
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<td>City:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<td>Home Phone:</td>
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<tr>
<td>Work Phone:</td>
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<tr>
<td>Cell Phone:</td>
<td></td>
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<tr>
<td>Fax Number:</td>
<td></td>
</tr>
<tr>
<td>E-mail:</td>
<td></td>
</tr>
</tbody>
</table>
Can you receive and send text messages?  
- Yes  
- No  

Do you check this email daily?  
- Yes  
- No  

Your role with the child(ren):  
- Custodial  
- Non-Custodial  

In the case of an emergency in which you are unavailable, whom do you authorize us to contact?

<table>
<thead>
<tr>
<th>First Name:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Last Name:</td>
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<td>Street Address:</td>
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<td>Cell Phone:</td>
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</tr>
<tr>
<td>Relationship:</td>
<td></td>
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</tr>
</tbody>
</table>

**Transportation**

How will you be transporting yourself/children/visitors to and from visits?  
- Own Vehicle  
- Public Transportation  
- Need Transportation  

- Riding with ____________________________

- Other ____________________________
Primary Vehicle Description:

Make____________________________________________________

Model___________________________________________________

Year_______________ Color________________________________

Employment Information

*If currently unemployed, check here □ and complete information on most recent employer.*

<table>
<thead>
<tr>
<th>Employer:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of Employment:</td>
<td></td>
</tr>
<tr>
<td>Street Address:</td>
<td></td>
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<tr>
<td>City:</td>
<td></td>
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<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<td>Work Phone:</td>
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</tr>
<tr>
<td>Supervisor:</td>
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</tr>
<tr>
<td>Regular Schedule:</td>
<td></td>
</tr>
<tr>
<td>On-Call Schedule:</td>
<td></td>
</tr>
<tr>
<td>Social Security #:</td>
<td></td>
</tr>
</tbody>
</table>
Domestic Violence Screening

Have you ever been a victim of domestic violence?  □ Yes  □ No
Have you ever been accused of domestic violence?  □ Yes  □ No
Have you ever been convicted of domestic violence?  □ Yes  □ No
Have your children been victims of domestic violence?  □ Yes  □ No
Have your children witnessed domestic violence?  □ Yes  □ No
Are there orders of protection in place?  □ Yes  □ No
If yes to any of the above, please explain: __________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Mental Health Screening

Have you been diagnosed with a mental illness?  □ Yes  □ No
Do you agree with this diagnosis?  □ Yes  □ No
Are you receiving counseling or therapy services?  □ Yes  □ No
Are you currently under treatment with a psychiatrist?  □ Yes  □ No
Are you currently under treatment with a physician?  □ Yes  □ No
Are you currently taking prescription medications?  □ Yes  □ No
Are you currently using any narcotic substances?  □ Yes  □ No
Have you been court ordered to submit to screening?  

- Yes  
- No

If yes to any of the above, please explain: ________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Child Information

In this section, please list information only about a child who will be participating in supervised visitation at this facility.

If there is more than one child, please request an additional form.

- I do not have this information; please obtain through the court.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Street Address:</td>
<td></td>
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<tr>
<td>City:</td>
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<td>Zip Code:</td>
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<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td></td>
</tr>
<tr>
<td>Grade:</td>
<td></td>
</tr>
</tbody>
</table>
Does this child have any health problems (e.g. disability, eating disorder, asthma, diabetes, allergies)?

- [ ] Yes
- [ ] No

If yes please describe:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Does this child have any emotional, mental, or behavioral problems (e.g. ADD, PTSD, anxiety, depression)?

- [ ] Yes
- [ ] No

If yes please describe:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Is this child currently on any medications for any of the conditions listed above or others?

- [ ] Yes
- [ ] No

If yes, please list medications, condition treated, and possible side effects:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Has this child ever been victim of or witness to domestic violence?

- [ ] Yes
- [ ] No

If yes please explain:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Has this child ever been victim of or witness to abuse, assault or trauma?

- [ ] Yes
- [ ] No

If yes please explain:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Are there any other concerns you have regarding this child and visitation?

☐ Yes  ☐ No

If yes please explain your concerns in detail:

__________________________________________________________________________

__________________________________________________________________________

☐ I am attaching _____ additional forms for _____ child(ren) who will also
be participating in supervised visitation.

Name(s):______________________________________________________________

Please attach any additional documents or information that you believe
may be helpful to us in better understanding and serving your family.

PLEASE READ THE STATEMENT BELOW CAREFULLY

I certify that the seven pages of information given above is true and complete and I understand that misrepresentation and/or withholding of information will result in the rejection of this application or my dismissal as a client if discovered after visitation begins. I understand the court will be notified of this dismissal and that this may affect custody arrangements.

I understand that no oral promises or guarantees relating to visitation are binding upon Lark’s Nest Family Counseling Center, LLC, and that, if accepted as a client, my visitation at this facility may be suspended any time that I or any part of my family become unsafe for the facilities and/or staff of Lark’s Nest Family Counseling Center, LLC. I understand that any termination as a client will be documented and that this documentation may be presented to the court.

________________________________________
Print Client Name

X________________________________________
Signature Date

X________________________________________
Witness Date
SUPERVISED VISITATION
CLIENT CONTRACT

The conditions of the Client Contract are based on our commitment to create a safe, neutral, and productive environment for child-parent interaction through therapeutic, supervised visitation. All parties will be held accountable for every part of the contract and it is crucial that each parent or guardian carefully read each of the following sections and then initial each section to indicate your agreement. If you have any questions or concerns about any part of this document, please contact Lark’s Nest Family Counseling Center, LLC, before initialing and signing the contract.

Client Relationship to the Center

_____ No client shall make excessive demands on the therapist or on the center’s resources. This includes but is not limited to contacting the therapist outside of supervision sessions and/or creating unreasonable difficulty in scheduling.

_____ No client shall share unsolicited personal information with the therapists or staff members of the center. Any and all information shared by clients following the signing of this contract may be documented and accessed by the visiting and the custodial parent.

_____ No client shall expect or request legal advice, investigative services, remedial parent education, or custodial evaluations as a result of enrollment in therapeutic, supervised visitation. Therapeutic, supervised visitation is not to be used as mediation or as venting sessions; the focus is on the parent-child relationship.

Parent Interaction in the Center

_____ Custodial and non-custodial parents need never have contact in regards to visitation. Your therapist will act as an intermediary between parents and guardians in the scheduling and management of visits.

_____ Neither parent nor any member of their families or other representative shall make any effort to initiate contact, either verbal,
physical, or visual with any member of the other party while on the premises including the parking area. This included service of court documents and/or requesting the intervention of law enforcement.

______ Neither parent shall try to extract information regarding the whereabouts or avenues of contact of the other parent either from staff or from the child(ren) before, during, or after a visit regardless of whether or not there is a restraining order in force.

______ Neither parent may use the child(ren) to relay or receive messages to or from the other Parent. Any necessary correspondence should be done through the therapist, if appropriate, or through a private attorney.

______ Rules regarding no-contact pickup and drop-off may not be waived, regardless of individual circumstances. If parents choose to interact it is a decision that must manifest outside of the services provided by Lark’s Nest Family Counseling Center, LLC.

Custodial parent

______ The custodial parent’s primary role in visitation is to drop-off and pickup children promptly and to provide support and understanding to the child(ren) participating in visitation.

______ It is the role of the therapist to record and regulate what occurs during visits and, while custodial parents may bring up concerns with the therapist, they should not assume the responsibility of trying to know everything that happened during a visit. Follow-up sessions, with the child(ren), the visiting parent, or the custodial parent will be scheduled in accordance with the treatment plan.

______ The custodial parent will bring the child(ren) to the office at the visit start time. Arriving early could result in contact with the non-custodial parent either in the office or in the parking area and is not allowed. Arriving late will delay the visit and take visitation time away from the non-custodial parent and the child(ren) which will be documented and, if significant, will be made-up.

______ The custodial parent will be in the office to pick up the child(ren) at the time the visit is scheduled to end and leave the premises immediately after collecting the child(ren) from the therapist.
_____ If medication is needed during visits, the therapist will require written permission and instructions from the custodial parent for the non-custodial parent to administer the medication. No therapist, employee, intern or contractor associated with Lark’s Nest Family Counseling Center, LLC will be responsible for the administration of any medication.

_____ Any allergies or dietary restrictions of the child(ren) participating in visitation must be reported to the center by the custodial parent at the time of intake / orientation as the non-custodial parent will be responsible for providing food and beverage for the child(ren) during the visit.

**Non-custodial parent**

_____ The non-custodial parent attends visitation for three reasons: firstly, to spend quality time with her/his child(ren) in a therapeutic setting; secondly to build attachment and establish or maintain an appropriate parent/child relationship and, thirdly, to demonstrate, in order to gain custody or visitation rights in court, that her/his parenting skills and parenting interactions with the child are appropriate and can be sustained. Throughout the visitation treatment plan, reports and progress notes made by the therapist. Any motivation for visitation that falls outside of these three categories will not help the child(ren) and should cause the non-custodial parent to reevaluate participation in visitation.

_____ The non-custodial parent is responsible for bringing food and drink for the child(ren) during the visit. Food items brought to the visit will be documented in the visit report and progress notes.

_____ The non-custodial parent must arrive no less than fifteen minutes before the scheduled start of the visit, parking where directed and entering the center through the appropriate door. The non-custodial parent shall wait in an assigned area that is physically and visually separate from the front lobby and parking lot after signing in and until the visit begins. This process ensures that there is no contact between the custodial and non-custodial parents preceding the visit.

_____ No member of the non-custodial parent’s family, friends, or other representative will be permitted to wait in the office or parking area. If the non-custodial parent receives a ride to the visit that ride must leave immediately and not return until fifteen minutes after the end of the visit.

_____ The non-custodial parent shall wait to be released by the therapist after the departure of the custodial parent and child(ren) in the assigned
area that is physically and visually separate from the waiting area and parking lot. This procedure allows the custodial parent and child(ren) to leave the premises without fear of being confronted or followed.

_____ The non-custodial parent may not, at any time during the visit, speak in any language other than that approved during enrollment. While Lark’s Nest Family Counseling Center does understand and respect that many families operate using multiple languages, we cannot permit the possibility of the therapist not being able to understand what is being said in session.

_____ The non-custodial parent may not make any inquiries or imply criticism regarding the custodial parent or his/her family. Visits should be concentrated on the child(ren) and should never be used as a means to collect information about anyone other than the child(ren) present.

_____ The non-custodial parent may not instigate any conversation about adult issues including CYFD investigations, court orders, adult relationships, or living situations. Parents must respond appropriately to any such conversation instigated by a child.

_____ The non-custodial parent must maintain emotional control throughout the visit. A visit may be stopped any time the therapist feels that the emotional state of the parent is causing stress for the child(ren).

_____ The non-custodial parent may not suggest activities that are outside of the CURRENT custody orders or activities that are pending approval from the custodial parent.

_____ The non-custodial parent may not bring gifts to the child(ren) without prior consent from the custodial parent via a Gift Approval Form unless the family has an established Open Gift Policy. The non-custodial parent will be allowed to bring one item for the child(ren)’s birthday and one item for any holiday during which the family would normally exchange gifts without custodial approval.

_____ The non-custodial parent is the only person automatically allowed to attend visits. Any additional visitor must be approved in advance by the custodial parent via the Visitor Request Form. This includes persons wishing to visit by phone/Skype during a session.

_____ The non-custodial parent may not ever remove the child(ren) from Lark’s Nest Family Counseling Center without the approval and accompaniment of the Therapist. If the non-custodial parent ever leaves
the premises with a child, or in the case of an off-site visit, leaves the session with a child, law enforcement and child welfare will be notified immediately.

_____ Children who are potty-trained will use the restroom alone. The non-custodial parent may wait in the hall and enter the restroom only at the actual request of the child or to assist with hand-washing. Under no circumstances may the parent use the toilet while the child is present in the restroom. Diaper changing will occur in the visit room under the normal supervision of the Therapist.

_____ Cell phones should be surrendered at the start of the visit and may be used for therapeutic purposes only during visits and only with the permission of the therapist. No photographs, phone/video calls, text messages, emails, entertainment games, or social media websites may be used by/shown to the child without prior approval.

_____ If the non-custodial parent chooses to engage in any activity that requires the Therapist to incur any out of pocket expenses, the expense shall be paid by the non-custodial parent. This includes admission tickets, entry fees and any other cost that is absolutely necessary in order for the Therapist to supervise the visit.

_____ All request forms must be filed at least three (3) days in advance of the visit date to which they pertain.

_____ The therapist is responsible for preparing the room in a way that encourages appropriate interactions between parent and child. The non-custodial parent is responsible for the cleanliness of the visitation space following the visit and for any damage to therapeutic materials resulting from the parent-child interactions in session. This is to encourage the non-custodial parent to demonstrate an appropriate level of authority in the session, to allow them to set limits and boundaries, and to apply consequences as appropriate to the situation. A $10 fee will be added for parents who choose not to return the visit room to the state in which they found it and a replacement fee will be charged for any therapeutic materials damaged in the session. These fees will be added to the regular visit fee of the next visit and no further visits will be allowed until it is paid.

_____ In cases in which allegations of sexual abuse have been substantiated and are indicated in the court order as a reason for referral, there is to be no physical contact, no exchanges of gifts money or cards, no accompaniment to the restroom, no photographing or recording of any kind, and no visitation at any location where alleged abuse occurred.
**Documentation**

_____ Lark’s Nest Family Counseling Center maintains extensive client files and detailed visitation reports so that information regarding the progress of visitation may be submitted objectively and professionally into court custody matters; the court requires that a release of information be in force throughout the entire course of treatment. All documentation must be ordered by and submitted for court/mediation by a parent using the Documentation Request Form. Documentation is provided at costs detailed on the fee schedule for the current year.

_____ Any information regarding a client will not be released to any party other than the client family and/or third-party payers unless the information pertains to suspected child abuse, violation of state or federal law, or is approved by the client to be issued to another individual such as an attorney, employer, or primary care physician.

_____ All parties are responsible for paying the fees associated with the documentation they request. Lawyers are not exempt and must either pay for the documents or defer the responsibility to their clients.

_____ Reports and progress notes must be requested in writing via the Documentation Request Form and paid in full at least seven (7) days before the documentation is needed.

_____ All documentation requested less than seven (7) days prior to the pick up date will be subject to an additional charge and are subject to denial based on therapist availability.

_____ Documentation will not be faxed or emailed and must be mailed (for an additional fee) or picked up in person by the requesting party.

**Scheduling and Cancelation of Visits**

_____ While Lark’s Nest Family Counseling Center, LLC, makes every effort to accommodate individual schedules it is crucial that both the custodial and non-custodial parents be as available as possible for visits. Visitation must be viewed as a high priority both for sake of the children and for custody issues. Your therapist will arrange for a regularly scheduled appointment, whether weekly, biweekly, or monthly and parents should ensure that visits actually occur as scheduled. This provides stability for the child(ren) involved. In special circumstances where regular visits are impossible, accommodations may be made.
Appointments will be made a minimum of seven (7) days in advance of the desired date of the visit (unless shorter notice is approved by all parties, including Lark’s Nest Family Counseling Center).

After three attempts have been made to schedule or reschedule a single visit, attempts will cease and a report will be filed with the court.

Any visit canceled within 48 hours of the scheduled occurrence for unknown or non-emergency reasons will be charged in the amount of $10 per hour to be paid by the parent who cancelled, regardless of whether that parent is the one who normally pays for visits.

Any visit cancelled without notice (no-show) will be charged in full to the absent parent. If both parents fail to appear the cost of the visit will be charged to the parent normally responsible for visit fees. Only cases of documented emergency in which contact to Lark’s Nest Family Counseling Center was made impossible will be forgiven. Documentation is required for any circumstances resulting in a missed visit and missed visits require that a make-up visit be scheduled within the week. Both parents are encouraged to carry the center’s phone number with them at all times in case the need to cancel should suddenly arise.

Fees

Every client will be provided with a current Fee Schedule during their orientation. Any change in fees will be presented to each party in writing 14 days before their implementation.

Clients with insurance must access their insurance benefits and allow for claims to be submitted for therapeutic sessions conducted by a licensed therapist, unless they agree to self-pay for all therapeutic visitation services in full. Documentation submitted to third-party payers will be limited to the diagnosis, service code, and dates of service.

Clients without insurance and/or clients whose insurance will not cover therapeutic supervised visitation, may apply for services on a sliding fee scale. This ensures that there is no financial barrier to participation in therapeutic supervised visitation for low-income families. Applications for the sliding fee scale are available at the time of intake; income verification and information on family size is required. Our sliding fee scale is based upon The Federal Poverty Guidelines, which are updated yearly.
and published in the Federal Register by the US Department of Health and Human Services.

_____ The party responsible for paying fees, as decided by court order or as agreed upon in writing, will pay each fee or co-payment in full prior to receiving the service. Visits must be paid for at the start of each visit and documentation paid for at the time of the request. Failure to pay in full prior to the time of service will cause the termination of the scheduled visit, incur a cancellation fee and require prepayment prior to the resumption of visits.

_____ Payments may be made by cash, check or, for an additional fee, credit/debit card. A credit card authorization form must be kept in force if payment will be made by credit card. A receipt will be given for each cash payment or credit card payments; cancelled checks will serve as a receipt for payments made by check. Monthly statements will be provided.

_____ Lark’s Nest Family Counseling Center, LLC, will exercise its right to contract with a collection agency to recover fees owed when they are 30 days past due. Attorney fees and costs shall be paid by the defaulting party within this contract should the need arise to seek legal or court action to recover fees due.

I, the undersigned client, agree to follow all rules and regulations of the above contract. I understand that violation of any of the conditions outlined above will be documented and could affect my custody if presented in court and/or my status as a client with Lark’s Nest Family Counseling Center, LLC. I further understand that the above rules and regulations are additions to the mandates and limitations set forth in state and federal law as well as any court orders or orders of protection that pertain to me and never supersede them.

__________________________________________
Print Name

X________________________________________ Date
Signature

X________________________________________ Dat
Witness
In this section, please list information only about a child who will be participating in supervised visitation at this facility. Please fill out a separate form for each child in supervised visitation and attach this form to your application.

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Street Address:</td>
<td></td>
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<tr>
<td>City:</td>
<td></td>
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<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td></td>
</tr>
<tr>
<td>Grade:</td>
<td></td>
</tr>
</tbody>
</table>

Does this child have any health problems (e.g. disability, eating disorder, asthma, diabetes, allergies)?  
- Yes  
- No  

If yes please describe: ____________________________________________________________

_______________________________________________________________________

_______________________________________________________________________
Does this child have any emotional, mental, or behavioral problems (e.g. ADD, PTSD, anxiety, depression)?  

- Yes  
- No 

If yes please describe: _____________________________________________

__________________________________________________________________

__________________________________________________________________

Is this child currently on any medications for any of the conditions listed above or others?  

- Yes  
- No 

If yes, please list medications, condition treated, and possible side effects: ________________________________________________

__________________________________________________________________

__________________________________________________________________

Has this child ever been victim of or witness to domestic violence?  

- Yes  
- No 

If yes please explain: _____________________________________________

__________________________________________________________________

__________________________________________________________________

Has this child ever been victim of or witness to abuse, assault or trauma?  

- Yes  
- No 

If yes please explain: _____________________________________________

__________________________________________________________________

__________________________________________________________________

Are there any other concerns you have regarding this child and visitation?  

- Yes  
- No 

If yes please explain your concerns in detail: __________________________

__________________________________________________________________
SUPERVISED VISITATION
Fee Schedule for Therapeutic Supervision

The fees assessed by Lark’s Nest Family Counseling Center, LLC are based on our commitment to create a safe, neutral, and productive context for child-parent interaction through therapeutic, supervised visitation. Our licensed therapists are highly qualified and session fees are based upon their level of licensure. If you have any question or concerns about fees, payments, or insurance claims, please contact the therapist directly or the billing department of Lark’s Nest Family Counseling Center, LLC (larks-nest-admin@comcast.net).

In addition, for clients without insurance and/or clients whose insurance provider will not cover therapeutic supervised visitation, a sliding fee scale is used at Lark's Nest Family Counseling Center. This ensures that there is no financial barrier to participation in therapeutic supervised visitation for low-income families. Applications for the sliding fee scale are available at the time of intake; income verification, tax returns, child support compliance, and documentation of household size are required to complete your application. Our sliding fee scale is based upon The Federal Poverty Guidelines, which are updated yearly and published in the Federal Register by the US Department of Health and Human Services.

Our regular fees are as follows:

- **Client Intake / Orientation:** $120 for non-custodial parent; $90 for custodial parent.

- **Therapeutic Visitation Session:** $90 per child for a 60-minute session, or any segment of this time interval, plus $20 per hour per additional child in same session (if allowed by court order). Travel time for off-site visitation and/or kinship visitation, is assessed at the same rate.

- **Consultation:** $90 per hour, or any segment of this time interval, to consult with Family Court Services, CYFD, attorneys, primary care physicians, and other mental health providers.

- **Visit Expenses:** Any food, beverage, supply, or admissions costs assumed by the therapist during a visit are to be reimbursed in full as
soon as possible after the visit and no later than the next scheduled visit.

- **Visit Report:** $10 per child, per report. Visit reports can be requested by the custodial and/or non-custodial parent. Please allow *three business days* after submitting a request and payment for the preparation of a visit report.

- **Treatment Summary Report:** $50 per report, available after every five visits, as long as your account is paid in full at the time of request. Treatment summary reports can only be requested by the visiting or non-custodial parent. Please allow *five business days* after submitting a request and payment for the preparation of a summary report.

- **Third Party Reporting:** If verbal or written correspondence is requested or required by a third party—and only upon written authorization to release information to said party—consultation fees apply for the preparation of correspondence.

- **Report Mailing:** $20 per mailing, via an express mail, flat rate envelope. In order to avoid a mailing fee and additional delays in processing, reports may be picked up at our office, *by appointment only* (in order to avoid potential contact between the parties).

- **Overtime:** $30 for every fifteen (15) minutes, or segment of this time interval, for supervision sessions that are extended due to the late arrival of the custodial parent.

- **48 Hour Cancellation:** No charge if notice is received within 48 hours; however, out of respect for our therapists and for other client families, we reserve the right to charge a $30 cancellation fee for repeated rescheduling and cancellations.

- **Late Cancellation / No Show:** Full session fee for each scheduled session missed.

- **Kitchen / Room Cleaning Fee:** $10 minimum, unless the room is restored to its original condition by the child(ren) and/or the non-custodial parent.

- **Damaged Equipment Fee:** Replacement value, for any destruction in session that should have been prevented by appropriate parental intervention on the part of the non-custodial parent. In
working with children, accidents can occur; this fee is not assessed in the case of accidental damage.

- **Court Appearance/Deposition:** $100 per hour, including travel time, waiting time, and mileage for therapist; $200 per hour, including travel time, waiting time and mileage for Clinical Director.

- **Mileage:** $.53 per mile

If you make application for the sliding fee scale and your application is accepted, fees will be adjusted according to your family size and your income range. If you are on the sliding fee scale, fees for intake / orientation, consultation, and visit fees are adjusted at the same percentage discount. There are no adjustments made for overtime, report preparation, mailing fees, cancellation fees, cleaning fees, reporting fees, damaged equipment fees, court appearance fees or mileage. All charges are to be paid in full prior to the scheduling of any additional therapeutic supervised visitation sessions, unless payment plans are made in advance with our billing department.

Requests for reports must be made in person or in writing to larks-nest-admin@comcast.net. Payment in full for reports and/or report mailing is expected at the time a request is submitted. Payment—by cash, check, or credit card—are all acceptable forms of payment at the time a request is submitted. We are unable to respond to requests for reports if your account is in arrears.

Please let us know if you have any questions regarding charges, as your signature on the intake paperwork is binding.

**This fee schedule is in effect as of August 1, 2016.**
Request Form

Child’s Name: ______________________________

I understand that all requests must be made at least seven (7) days in advance; requests can be faxed to 505-954-1453. If the request is not appropriate for the course of family treatment, the therapist, who has the final say, will deny the request. S/he may also indicate a point in future when the request would be more appropriate. If the court order indicates that the permission of the custodial parent is required, the therapist will serve as an intermediary in obtaining consent.

I would like to make the following request(s):

I. Gift Request: I would like to bring a gift, in the form of ______________________

________________________________________________________________________

for my child on ________________________________.

☐ Approved  ☐ Denied by ________________________________

II. Authorized Visitor Request: I would like the following person(s) to participate in supervised visitation: ________________________________

________________________________________________________________________

This person is related to my children in the following way: ________________________________

________________________________________________________________________.

I am request a one-time attendance on ________________________________
or ongoing attendance beginning on ________________________________.
If my request is approved, I understand that the visitor will be asked to follow the same policies that are included in my contract.

☐ Approved  ☐ Denied by ________________________________

III. Off-Site Visit: I would like to request a walking visit / driving visit / in-home visit (please underline one type of visit) on ____________________

to the following destination or location________________________________
________________________________________________

☐ Approved  ☐ Denied by ________________________________

________________________________________
Print Name

X__________________________________________ Date
Signature

X__________________________________________ Date
Therapist

X__________________________________________ Date
Custodial Parent
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Comments/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>I demonstrate appropriate affection for my child.</td>
<td></td>
</tr>
<tr>
<td>I am consistent, firm, and fair when I discipline my child.</td>
<td></td>
</tr>
<tr>
<td>I teach my child to identify choices and make independent decisions.</td>
<td></td>
</tr>
<tr>
<td>I know where my child is, what he or she is doing and with whom.</td>
<td></td>
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<tr>
<td>I establish family routines that include meals and study time together as well as other activities.</td>
<td></td>
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<tr>
<td>I require my child to participate in the routine chores and productive work of the family.</td>
<td></td>
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<tr>
<td>I display my child’s school work on a wall, refrigerator, or bulletin board.</td>
<td></td>
</tr>
<tr>
<td>I teach my child to respect other adults and authority.</td>
<td></td>
</tr>
<tr>
<td>I make sure my child knows the rules and expectations in our household.</td>
<td></td>
</tr>
<tr>
<td>I read and respond to information sent home regarding achievement of my child.</td>
<td></td>
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<tr>
<td>I teach my child to tolerate differences in others.</td>
<td></td>
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<tr>
<td>---------------------------------------------------</td>
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<tr>
<td>I help my child when he or she is having difficulty in school.</td>
<td></td>
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<tr>
<td>I set an example for my child for not abusing alcohol or drugs.</td>
<td></td>
</tr>
<tr>
<td>I hug and show affection to my child daily.</td>
<td></td>
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<tr>
<td>I stress the importance of education by daily reading, checking homework, and participating in teacher conferences, open houses, and volunteering time or resources.</td>
<td></td>
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<tr>
<td>I know my child’s teachers and stay in contact with them.</td>
<td></td>
</tr>
<tr>
<td>I make sure my child is in school and on time every day.</td>
<td></td>
</tr>
<tr>
<td>I set the example of hard work and personal responsibility.</td>
<td></td>
</tr>
<tr>
<td>I set aside time each day for my child to share with me what he or she has done in school.</td>
<td></td>
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<tr>
<td>I see that my child has sufficient rest and nutrition daily.</td>
<td></td>
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<tr>
<td>I take care of my child and myself through regular medical and dental care.</td>
<td></td>
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<tr>
<td>I praise my child for his/her good behavior and efforts.</td>
<td></td>
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<tr>
<td>I set a good example for my child by volunteering at my child’s school and in the community.</td>
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<tr>
<td>I plan a family meeting once a week.</td>
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<tr>
<td>I encourage regular family involvement activities.</td>
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<tr>
<td>I understand the importance of avoiding drugs, alcohol, and other medications which the doctor feels would be unsafe during pregnancy or in the presence of my children.</td>
<td></td>
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<tr>
<td><strong>Parent's Name:</strong></td>
<td></td>
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<tr>
<td><strong>Parent's Signature:</strong></td>
<td></td>
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<tr>
<td><strong>Date:</strong></td>
<td></td>
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</tbody>
</table>
SUPERVISED VISITATION
Report Request Form

Payment for visit reports must be made at the time of the request: reports will not be prepared or mailed until payment is received.

I am requesting the following documents:

- **Visit Report**: $10 per child, per report. Visit reports can be requested by the custodial and/or non-custodial parent. Please allow three business days after submitting a request and payment for the preparation of a visit report.

- **Treatment Summary Report**: $50 per report, available after every five visits. Treatment summary reports can only be requested by the non-custodial parent. Please allow five business days after submitting a request and payment for the preparation of a summary report.

**Child’s/Children’s Name(s):** ____________________________________________________________

____________________________________________________________________________________

**Report Date(s):** _____________________________________________________________________

____________________________________________________________________________________

I understand that there is an additional fee of $20 assessed for the mailing of my report(s), via an express mail, flat rate envelope. In order to avoid a mailing fee and additional delays in processing, reports may be picked up at our Medico Lane office, by appointment only (in order to avoid potential contact between the parties). Therefore, I would like the requested documents to be:

- **Mailed** to me at the following address: ____________________________________________________________

____________________________________________________________________________________

- **Prepared** for me to pick up on: ___________(Date) at __________(Time).

____________________________________________________________________________________

Total Fee Paid: __________________

Please Print Your Name

X ____________________________________________  Please Sign Here  Date

422 Medico Lane, Suite D, Santa Fe, NM  87505
505-954-1365 Phone  505-954-1453 Fax