SERVICES INVOLVING LEGAL ISSUES

If you request that any professional through Child Psychiatry Associates, P.C., provide consultation to any legal personnel, you must complete **both** of the following forms:

- Consent for Release of Privileged Information to Legal Counsel and/or Court Personnel
- Agreement for Forensic Services

Each of these forms must be completed in their entirety, signed, and witnessed by an individual over the age of eighteen years. If you complete the forms in our office setting, you may ask one of our office staff to sign as your witness.

Please check the Consent for Release form before you turn it in to make certain all of the following have been completed:

1. You have provided your name and date of birth
2. You have provided your complete address, including the zip code
3. You have provided the full name and date of birth for each child
4. You have provided the full name of your attorney, along with the office address and telephone number of that attorney
5. You have signed the first page of the form
6. You have signed the second page of the form
7. You have obtained a witness signature

Thank you.

Child Psychiatry Associates, P.C.

939 Office Park Road, Suite 200
West Des Moines, Iowa 50265 (515) 288-5570
E-mail childpsychiatrya@qwestoffice.net Fax (515) 440-3388

CONSENT FOR RELEASE OF PRIVILEGED INFORMATION TO LEGAL COUNSEL AND/OR COURT PERSONNEL
Page One of Two

Please complete this form in its entirety. This release is not valid if it does not contain an original signature or if the date of expiration has passed. You must complete each page of this two page document.

I understand that, as part of the services I am receiving through Child Psychiatry Associates, P.C., the content of the services offered to me and to my child(ren) is subject to review by the legal counsel representing each parent as well as by the Court overseeing any legal matters. As such, I hereby consent to disclosure of information as follows: Any and all information utilized as part of any evaluation process (including a custody study), any and all information regarding my mental health care at any facility (past and present), any and all information regarding treatment for alcohol/drug abuse at any facility (past and present), and any and all information gathered through the course of these services in regard to my children, (including mental health/psychiatric care/treatment for alcohol/drug abuse) who are listed below by their full name and date of birth.

MY NAME/DATE OF BIRTH: _____

MY ADDRESS: _____

MY CHILDREN'S NAMES AND DATES OF BIRTH: _____

_____

The privileged information is to be received from and disclosed to the following parties:

- **The** _____ **County Courts**
- **The attorney/attorney's staff representing the children's father:** _____

  Attorney's complete address, including telephone number: _____
- **The attorney/attorney's staff representing the children's mother:** _____

  Attorney's complete address, including telephone number: _____
- **The attorney/attorney's staff representing the children:** _____

  Attorney's complete address, including telephone number: _____

_____

Signature and Date Signed

CONSENT FOR RELEASE OF PRIVILEGED INFORMATION TO LEGAL COUNSEL AND/OR COURT PERSONNEL

- **This release covers the periods of service from the first date of service until the final date of service.**
- **The purpose of this release is to coordinate services across the mental health and legal settings.**
- **In regard to minor children, some information about services involving each parent may be documented in the records and, upon the discretion of the professional working with the family, information which is needed as part of the overall treatment and legal process may be relayed to the child's other parent.**
- **This release provides that any and all information contained in the clinical files of all parties cited above by name/date of birth can be disclosed.**
- **Child Psychiatry Associates, P.C. may require compensation for copying records, consultations, and any other professional services.**

Affirmation of Release: I give Child Psychiatry Associates, P.C. permission to release only the information I have selected on this form to the individuals or agencies named on page one and only for the stated purpose. I understand this release is valid up to one year from the date I sign it. I may refuse to sign this authorization or revoke the authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain mental health treatment nor will it affect payment or my eligibility for benefits. However, if you are participating in court-ordered services, Child Psychiatry Associates, P.C. may choose to refer you to another provider if you refuse to sign authorizations that allow for the completion of the court-ordered services. Any revocation of consent will take effect on the day that the written statement of revocation is received by Child Psychiatry Associates, P.C. As a client, I have the right to access my treatment records; copies of the records may be obtained with reasonable notice and with payment of copying costs. Because services involving legal issues often also involve multiple parties, I recognize the entire record cannot be released to me unless I have obtained written consent from every involved party eighteen years of age or older, if that individual was receiving direct treatment services or was receiving direct evaluation services. Consent is not required for individuals who provided collateral information as part of an evaluation process or who willingly participated in services for an identified patient at Child Psychiatry Associates P.C. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and may no longer be protected by state or federal regulations.

_____

Signature and Date Signed

_____

Signature of Witness and Date Signed

This consent expires one year from the date signed : _____

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AGREEMENT FOR FORENSIC SERVICES

If your care through our office involves the coordination of services for legal issues, please be advised these services cannot be billed to your insurance carrier. You will be billed directly for the following services at a rate of $195 for psychologists and social workers and $295 for psychiatrists: preparation of reports/letters and telephone/ in-person consultations with attorneys and others involved in the legal process.

Court appearances are billed in one-half day increments. In addition to this, the professional involved will bill for time spend preparing for the testimony as well as travel time. The rate for court appearances is:

- **Psychologists and social workers: $800/per half day plus fees for preparation and travel**
- **Psychiatrists: $1200/per half day plus fees for preparation and travel**

All fees related to court appearances must be paid 48 hours in advance of the actual testimony. If the fee is not paid in advance, our office will notify the attorneys and the Court that the subpoena cannot be honored. If the testimony is cancelled with less than 48 hour notice, you are responsible for the full fee and it will not be reimbursed to you. With a subpoena, you are demanding a professionals' time and are responsible for all fees related to this.

Our office must receive a subpoena for all required testimony. Reasonable notice of at least five business days is required. Our office does reserve the right to decline a subpoena that is given without adequate notice, as defined by Iowa law. The professionals at Child Psychiatry Associates, P.C., have obligations to other individuals who have scheduled appointments; we are not willing to place the treatment needs of others at risk and, accordingly, simply must have adequate notice if we are required to be away from our offices.

Please make certain you have signed all necessary consent forms before your attorney contacts any professional or office personnel at Child Psychiatry Associates, P.C. The balance of all fees related to reports, letters and legal consultations must be paid within thirty days of the billed services.

I have read the forensic policy described above and I agree to the terms.

Signature and date: _____

Signature of witness over age 18; date: _____