From the desk of

SUZANNE NIXON, EdD, LPC, LMFT

POLICIES REGARDING COUNSELING, LEGAL ISSUES & COURT RELATED SERVICES

I as your therapist am providing counseling services for either you, your child, or family members. There are times when marriages end and couples decide to divorce. There are times when issues of child custody and parental visitation arise. **As your therapist, I provide counseling treatment. I do not provide court related services or evaluations of any type.**

Please read each statement paragraph. By initialing, you are stating that:

"I understand that Dr. Suzanne Nixon provides counseling services and treatment, and does not act as a psychological evaluator or an evaluator for custody or visitation issues." _____

"I agree to not involve her in any psychological/custody/violation disputes. I understand it would not be in the best interest of my treatment relationship, or my child's, or any family member, and it would be counterproductive to my therapeutic process." _____

"I agree to not call her as a witness (subpoenaed) at any court hearing or trail, arbitration, mediation or any other tribunal. I understand that my therapist is not obligated to respond, return, or relay any professional opinions to others, and I agree to these terms. If my therapist does respond to any request for an opinion, it shall not serve to waive this clause." _____

"I understand that I am expected to pay for all Dr. Suzanne Nixon's professional time in phone consults/writing, all preparation for consults or court services if subpoenaed, transportation costs, and any legal fees incurred, even if I am called to testify by another party. Payment is expected in advance, and any payment exceeding hours spent will be returned to the client. _____

OTHER FEE SCHEDULE:

For any legal or court related services, including preparation:
My Fee is: $500. per hour
If I am called to testify by you or another party, and go to court:
My Fee is: $5,000. per day
Fees are collected prior to services, and will be prorated for reimbursement if hourly time is less than originally expected. I have read this statement of policies and fees and understand and agree to the terms of Dr. Suzanne Nixon's policies and practices.

_____ _____

Signature **Printed Name**

Date _____ Therapist's Signature _____