Dr. Brad S. Broeder
Clinical & Forensic Psychologist
Florida & NYS Licensed

#1266 First Street
Suite # 11
Sarasota, FL 34236-5519

(941) – 953 – 6804
Fax: (941) – 953 – 3704
E-mail: DrBBroeder@gmail.com

Child/Adolescent Therapy
PROFESSIONAL SERVICE AGREEMENT

Welcome to the office of Dr. Brad S. Broeder, clinical and forensic psychologist. This document serves to introduce the 'role' and purpose(s) regarding what type and kind of psychological service(s) that Dr. Broeder shall be able to supply. In addition, this 'agreement' shall also explain and provide assurances as to your 'Right to Privacy' as dictated under the HIPPA regulations and, in accordance with the functional operation of Dr. Broeder's office.

Herein, Dr. Broeder is a licensed professional who shall strive to assist you, your spouse/partner and/or your child(ren) in achieving any goal(s), reducing emotional conflict(s), diminishing any worries and, assisting in problem-solving; especially as related to the current personal, familial, educational and/or legal matters, including any necessary litigation. The role of this psychologist is to remain neutral while functioning in the capacity as the mutually agreed upon clinician and/or evaluator to help, assist your child/children and, if applicable you and/or the 'other' parent to accomplish goals, reduce conflicts or overcome fear(s), or; to serve as a forensic specialist to evaluate 'issues'.

However, in this capacity there cannot be any guarantees as to the results of the therapeutic efforts or, the evaluative results, although every effort shall be made to ensure conflict resolution and improved mental/emotional health for all involved.

During the course of this therapeutic process there may be a need to speak with family relatives, neighbors, teachers, etc., who shall serve in the capacity of 'collateral contacts'. These individuals provide Dr. Broeder with additional information and insights into the specifics of you and/or your familial situation. Given that the role of Dr. Broeder is that of clinician, the primary rule is that of upholding the concept of 'confidentiality'. Herein, every effort shall be afforded to keep you and/or your family's communications privileged and private. However, on that rare occasion when the health or safety of your child is in question the rule of confidentiality may need to be waived. Such a decision shall be at the discretion of Dr. Broeder.

In such an event, by signing this agreement you, as the individual/spouse/parent are acknowledging that Dr. Broeder may have to reveal, share and/or dispense diagnostic and/or therapeutic information in order to facilitate and/or assist other professionals to secure the safety of your child and/or the family. This is specifically true if your familial situation were to require legal services and litigation.

PROFESSIONAL SERVICE AGREEMENT
(PSA)
(Pg. # 2)

This psychological service is meant to be a bi-lateral experience whereby any question(s) as to the process and/or procedure(s) of the therapy, consultation, intervention(s) and/or evaluation are welcomed and shall be discussed in the attempt to better serve your mental and emotional needs, as well as those of any family members. However, please be advised that Dr. Broeder may choose not to divulge or share every single fragment of what is discussed if he believes it might compromise the family's sense of privacy and/or violate the oath of 'confidentiality'.

As part of this collaborative process you will need to complete the information below so as to demonstrate that you are willfully granting and;

'AUTHORIZING CONSENT FOR PSYCHOLOGICAL SERVICES'.

I, _____, on this date, _____, do hereby grant permission for myself, and, my child/children, who is/are named, _____ and, for me and my (Ex)-spouse or partner, if therapeutically necessary, to participate in any 'consultation'(s), therapy session(s) or, undergo a/an psychological consultation(s), treatment(s), testing, evaluation(s), observation(s), counseling, conjoint family treatment and/or psycho-diagnostic interventions with Dr. Broeder. I understand that Dr. Broeder is a clinical and forensic psychologist, licensed in the State of Florida. I further understand that Dr. Broeder, serving as the 'psychologist' will adhere to and uphold the standards set forth by the American Psychological Association, (APA) and the Florida Statutes of Professional & Ethical Conduct. ***I do hereby agree to cooperate with Dr. Broeder and his staff***, as I understand that he will be making every effort to work for the best interests of my child, children, myself and/or my family, without being able to guarantee any specific results.

By virtue of my choosing to seek out Dr. Broeder for psychological services I recognize that, ***I am granting consent for myself, and/or parental permission for my child or children,*** for any and all psychological services to be rendered under his supervision and guidance. The right to terminate services at any point during this process is reserved to both parties. Furthermore, I understand that Dr. Broeder's office works as a, ***'fee-for-service' operation*** and that the current 'agreement' is such that I, the individual or, as the 'Patient', shall be required to pay for each office visit at the rate of $200/hr. Or, I may opt to select the 'retainer' option and thereby pay the amount of $1,800 which is based on the rate of $200/Hr. for the first ten (10) sessions. Either option is workable and therefore you have a payment option. Payment may be made by check, cash or by credit card. If you opt to pay by credit card please understand that there will be a .0375% fee affixed to the actual session fee; (approximately $6.75).

PROFESSIONAL SERVICE AGREEMENT

(PSA)
(Pg. # 3)

As stated, I thereby agree to and understand that Dr. Broeder charges $200/Hr. for each individual or group diagnostic session, meeting or observation period and that I am 100 % responsible for the costs of such services. Dr. Broeder's office is a 'fee-for-service' entity, therefore I can expect that all billing shall be copied and shared with me upon request. In addition, ***there is a twenty-four (24) hour cancellation policy*** in effect, indicating that with less than twenty-four (24) hours notice that I will be charged the regular meeting/session fee for that missed or canceled appointment time, as Dr. Broeder had specifically reserved that appointment time for my child, myself or my family and therefore he requires remuneration for all service time(s) allowed and scheduled on my behalf.

By reading and completing this *'authorization for consent of services'*, I do hereby acknowledge and agree to the working conditions under which Dr. Broeder operates his practice; specifically as related to his serving as the 'therapist', 'consultant', 'clinician', and/or evaluator in/for my personal situation.

Name: _____. Marital Status:_____.

Home Address: _____.

Contact Numbers: (H)# _____ ; (C)# _____; (W)# _____ .

Date of Birth: _____ . Age: _____ . Email: _____.

Profession/Occupation:_____.

Educational background: _____ .

Previous Therapy Experience(s): _____.

Primary Reason(s) for Psychological Services: _____

_____

_____

_____

_____ .

Signature: _____ . Date: _____ .

Spouse/Partner/Significant Other :_____.

His/Her Occupation:_____.

His/her Date of Birth & Age: _____ .

Educational Background: _____.

His /Her Contact Information: _____.

Spouse/Partner's Email Address: _____.

Children's Name(s) & Age(s): _____

_____.

Description of Precipitating Event(s) that led to the referral for therapy?

_____

_____

_____

_____ .

Child(ren)'s School & Grade level:_____

_____

_____

_____ .

Description of your daily home-life routine with your child:

_____

_____

_____

_____ .

Description of your Current Problem(s): _____

_____

_____

_____ .

What do you believe is the cause or primary reason behind the problem?

_____

_____

_____

_____ .

Description of your parental-personality type: _____

_____

_____

_____

What is your perception of your child/children's relationship with the Mother? And, with the Father?

_____

_____

_____

_____ .

What type of activities do you enjoy or participate in with your child(ren)?

_____

_____

_____ .

How do/does your child/children perform in school? _____

_____

_____

_____.

What if any, behavioral or attitudinal problems do/does your child/children pose to you and/or the other parent?

_____

_____

_____.

How would you describe the style of communication between you and your spouse/partner, or the 'other' parent?

_____

_____

_____

_____

_____

_____.

Have you or anyone else in your family ever sought out psychological services prior to today, (if yes, please explain):

_____

_____

_____

_____.

Do you or anyone in your family have any type of addiction or problems with alcohol, prescription drugs, gambling, etc.? (If yes please explain):

_____

_____

_____ .

Please use this space to add or include any additional information that you believe would be useful/helpful for Dr. Broeder to best understand and comprehend what your are dealing with and what your goals are:

_____

_____

_____

_____

_____

_____ .

If you are choosing to pay by credit card please provide the following information:

Name as it appears on your card: _____ .

Credit Card #: _____ . Expiration Date: _____ .

CVS or security code #: _____ . Type of Card: _____ .

Name of your Bank: _____ . Billing Zip Code: _____ .

_____ _____

Print your name **Today's Date**

_____

Signature

<consent-newpt-Ch>