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

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Personal/Parental 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 and/or guide you and/or your family, to reduce conflicts, decrease tension, improve communication, develop a/an shared goal(s) or, provide expert witness testimony.

However, in this capacity there cannot be any guarantees as to the results of the therapeutic efforts, the evaluative results or testimony, although every effort shall be made to ensure conflict resolution, improve emotional health and/or provide psychological opinions/feedback to the court(s) to help reduce conflict for all involved.

During the course of this Psychological 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 clinical psychologist, 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 those occasions when the health or safety of you or your child is in question or, there is a calling for testimony the rule of confidentiality might be waived. This decision is 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 adjudicate what is 'in-the-best-interests' of your family given any legal processes.

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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 testimony, 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 will not divulge or share any information without first speaking with you and obtaining your written permission as he will not compromise the family's sense of privacy and/or violate the oath of 'confidentiality'.

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

'AUTHORIZING CONSENT FOR PSYCHOLOGICAL SERVICES'.

I/We, _____, on this date, _____, do hereby grant permission for myself/us, and, if applicable my child/children, who is/are named, _____ and, for me and my spouse/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 States of Florida & New York. I further understand that Dr. Broeder, serving as my '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 myself, my child, children 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 the cost of therapy is based on the hourly rate of $200/hr. Also, it is hereby agreed that all fees will be paid on the day of the appointment(s) by check, cash or credit card. Although Dr. Broeder will not charge for phone or email communications, unless those 'talks' were to exceed ten minutes, there is a 3.75% (.0375%) processing fee added to the charge(s), if you elect to pay by credit card.

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As stated, I thereby agree to and understand that Dr. Broeder charges $200/Hr. for each individual session (after the initial consultation) and that I am 100% responsible for the costs of such services. However, an invoice shall be provided.
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 me and/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: _____ .

(Ex)Spouse/Partner's Name:_____.

Profession/Occupation:_____.

Date of Birth & Age: _____ .

Educational Background: _____.

Contact Information: _____.

(Ex)Spouse/Partner's Email Address: _____.

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

_____.

Description of Precipitating Event(s) that led to you being referred?

_____

_____

_____

_____ .

Description of Your Personality: _____

_____

_____

_____ .

Description of your (ex)spouse/partner's Personality:

_____

_____

_____

_____ .

Description of any current problem(s) between you and your (ex)spouse/partner:

_____

_____

_____

_____.

Describe the type or nature of problem(s) you may/might have with your child(ren):

_____

_____

_____

_____.

Describe How you and/or your partner enjoy your leisure time together:

_____

_____

_____.

What is your perception of your child/children's relationship with Mother? With Father?

_____

_____

_____

_____.

What type of issues or problems, if any, do you have with your in-laws/relatives?

_____

_____

_____.

How do relate to friends and family members? _____

_____

_____

_____.

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 (ex)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 what the issues were):

_____

_____

_____

_____.

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

_____

_____

_____ .

Have you or anyone in your family ever been a victim of any type of trauma or abuse? (be it physical, sexual or emotional abuse, etc.)? (Please describe):

_____

_____

_____

_____;

(please use the other side of this page if you require ore room to compose your answer).

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ .

*** For those individuals who are agreeing to pay all service fees with their credit card please read, complete and sign the following:

"I understand that Dr. Broeder charges ***$200/Hr.*** for his time. This time includes email correspondences, emergency phone calls, the administration and scoring of tests, extra

time, extended phone calls and, any and all individual, group or family sessions. I do thereby grant Dr. Broeder permission to charge my credit card for the services described herein. Account #: _____ , with the Expiration Date of _____, and a CVV code of _____. I further understand and agree that for any and all charges there is a small, additional service fee charge of .0375% added or calculated to the existing charge; which amounts to approximately $6.75. By reading, completing and signing this form I acknowledge that I have granted Dr. Broeder to charge my card for any and all of his psychological services.

_____ _____

Print your name **Today's Date**

_____

Signature

<consent-newpt-tx>