*From the desk of*

**SUZANNE NIXON, EdD, LPC, LMFT**

**POLICIES REGARDING COUNSELING, LEGAL ISSUES & COURT RELATED**

**SERVICES**

I am providing counseling services for either you, your child, or family members. There are times when marriages end and couples decide to divorce. **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, or any other legal court proceedings.” \_\_\_\_\_

“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.**

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**Signature Printed Name**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**