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# Shared Custody Agreement

This agreement is made between the client's parents and ___________________________.
**(Psychotherapist)**

I, ________________________________ understand and agree to the following:
**(Please print parent name here)**

I understand that communications between the child/adolescent and the therapist are confidential, subject to the limitations specified below.

I understand that certain limitations to confidentiality will apply according to North Carolina State Law in which the therapist has the duty to report information concerning suspected child abuse, which included sexual abuse, physical abuse and neglect. The clients and the therapist acknowledge that once such allegations are reported, the therapy can still continue if all parties agree.

I agree to fill out all client forms found on the Triangle Psychological Services' website (trypsych.com) specific to my child/adolescent's age and send them in before I schedule a meeting with ___________________________, as well as this form, so that I am clear about client
**(Psychotherapist)**
confidentiality and guidelines.

I understand that _____________________________ will inform the parents of
**(Psychotherapist)**
the general goals and progress of treatment, either by a brief summary to all parents or through a parent-therapist session, and that parents will be provided with a general understanding of the main content issues of the therapy. However, the child/adolescent is given the right to confidentiality, in that, specific issues discussed may not be communicated to the parents if it is deemed best to maintain the child/adolescent's privacy or if the therapist is requested by the child/adolescent to do so (that remains under the aforementioned psychotherapist's discretion).

Communication about therapy other than scheduling can only take place in the Triangle Psychological Services office, not through phone calls or emails. I understand that if I live outside of the Raleigh-Cary area, I will provide aforementioned psychotherapist with a phone card, to be used for scheduling purposes only, which will be returned to me when the therapeutic relationship is terminated. Therapy is on a fee for service basis: the cost of the first and subsequent sessions are listed on the Schedule of Fees document found on the website or sent by mail (unless the fees are revised and I receive a month's notice about this). Payment must be brought to each session. We will file claims to your insurance company and they will mail you the reimbursements. Debit or credit cards may be used at the time of the appointment; but office policy prohibits using credit or debit card numbers over the phone for safety reasons. Triangle Psychological Services can, of course, accept check payments sent in advance of the scheduled sessions. If I am the noncustodial parent, I will respect the therapeutic relationship between my child and the aforementioned psychotherapist, and will accept reasonable recommendations about family sessions, waiting for my child's readiness to engage in therapeutic conversation as directed by the aforementioned psychotherapist.

I agree that I will not call ___________________________________ as a witness
**(psychotherapist)**

in any legal action having to do with the issues discussed in this treatment. However, the aforementioned psychotherapist ***may*** be willing to discuss the therapy with a court ordered Special Master, Parent Coordinator or court ordered Custody Evaluator, to provide information and opinions that might be helpful to such a professional in determining the best interests of the child/adolescent.

I understand and agree that although any previously completed evaluations, psychological summaries or reports may have been the subject of testimony or court proceedings, the psychotherapy sessions now being agreed upon shall be confidential and not made subject of testimony or of a subpoena for court purposes to produce any written documents which may be prepared during the course of psychotherapy. I agree to this to protect the confidential nature of my child/adolescent's therapy sessions and help my child/adolescent progress and resolve conflicts.

Signed: ________________________________ Date: _______________
Parent

Signed: ________________________________ Date: ________________
Parent

Signed: ________________________________ Date: ________________
Psychotherapist

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