

**LYN R. GREENBERG, PH.D., ABPP**  
**11340 W. Olympic Blvd., Suite 265**  
**Los Angeles, CA 90064**  
**(310) 399-3684**  
**(310) 988-2706 fax**  
**lyn@lyngreenbergphd.com**

CONSENT TO TREATMENT, FEE AGREEMENT

I hereby consent to psychological treatment for myself and/or my child(ren), \_\_\_\_\_, by Lyn R. Greenberg, Ph.D. I understand that Dr. Greenberg is required to report any suspected child abuse, and any situation in which I or a member of my family is a danger to self or others. I also understand that I will be charged for any appointment that is not attended or is canceled with less than 24 hours' notice. I understand that I am responsible for payment of all fees for these services.

A advance payment of \$2500 is due at onset of services. This will be charged against and any remaining balance will be returned to the client/parents. Additional advance payments may be required when the initial payment is exhausted or reaches a predetermined level. I agree to provide payment within ten days of receiving an invoice or request for additional funds. I agree to maintain a balance of \$1500 on account with Dr. Greenberg and to replenish that amount when requested.

I understand that fees for these services are as follows: \$365 per 45-50 min. session or meeting. Additional charges apply to longer sessions. These fees also apply to services provided outside of therapy sessions. Such services include (but are not limited to) telephone calls, review of documents, preparation of records, reports, depositions, research, declarations, consultations with counsel, and court attendance/testimony. **I understand that Dr. Greenberg does not accept insurance company contracted (i.e., managed care) rates. I understand that some services in court-related cases may not be covered under my insurance plan. Dr. Greenberg will provide billing statements which I may submit for insurance reimbursement, but payment for Dr. Greenberg's services is my responsibility, unless such responsibility has been otherwise established via court order or agreement with Dr. Greenberg.** Fees are subject to change with 8 weeks' notice to the parties.

Dr. Greenberg may request the involvement of other household or family members as she deems appropriate. The parents acknowledge that, when a child is involved in counseling, the child is considered to be Dr. Greenberg's primary client/patient. Parents are adjunct/collateral participants in counseling directed toward the welfare of the child. I understand that, when an adolescent is in treatment, a certain element of treatment privacy may be essential. I understand that Dr. Greenberg manages sharing of treatment information with the goal of keeping parents generally informed but also protecting and facilitating progress for the child as much as possible. I agree to consult with Dr. Greenberg and attempt a managed sharing of information prior to initiating legal steps to obtain my child's information.

I agree to cooperate with Dr. Greenberg, including, but not limited to, (1) paying for services in a timely manner in accordance with the fee agreement executed by the parties with the Dr. Greenberg, (2) ensuring that the minor child(ren) are transported to and from scheduled appointments in a timely manner; and (3) exercising parental authority to require that the minor child(ren) attend(s) and cooperate(s) with treatment; (4) making schedule adjustments to allow Dr. Greenberg to see my child(ren) with both parents, as consistent with applicable court orders.

\_\_\_\_\_  
Client/Parent Initials

\_\_\_\_\_  
Attorney Initials

I understand that successful psychotherapy for children often requires that parents make changes in their own behavior and parenting, to support their children's needs. Dr. Greenberg may request specific changes in such areas as setting appropriate limits for children, encouraging children to express feelings and solve problems appropriately, listening to children's concerns, actively supporting children's independent relationships, and shielding the children from parental conflict. I agree to make reasonable efforts to cooperate with Dr. Greenberg's requests in these areas. If I disagree with requests or recommendations made by Dr. Greenberg, I will discuss those concerns privately with Dr. Greenberg, and will not allow the child to witness or overhear such concerns.

I have had the opportunity to review this agreement with my attorney, and to ask any questions they may have concerning Dr. Greenberg's approach to treatment and other alternatives that may be available. The structure, frequency, duration, and participants in therapy sessions will be determined by Dr. Greenberg.

Dr. Greenberg will not make recommendations as to custody or parenting plans, nor determinations regarding the child's best interests, as these are outside the therapists' role. She may make recommendations to the parties regarding changes in the parent-child relationships that may be helpful to the children in implementing the Court's orders.

Except as authorized herein, Dr. Greenberg will keep confidential all information obtained in counseling except when mandated by law to report suspected child abuse and where a person appears to be a danger to him/herself or others.

I understand that, if Dr. Greenberg is permitted by waiver or required by law or court order to provide information to anyone, including counsel, a child custody evaluator and/or the Court, the information released may include information that might otherwise be considered to be protected under the Health Insurance Portability and Accountability Act (HIPAA).

Should any dispute arise as to whether a communication is privileged, Dr. Greenberg will refer the issue to the court for resolution, and will refrain from disclosing the information in dispute until directed by the Court. Dr. Greenberg will obey any order from the trial court regarding release of treatment information provided by the parents or children. The parties agree to hold Dr. Greenberg harmless regarding any release of information provided based on good-faith adherence to a waiver or Court order, and for any delay resulting from a good faith decision by Dr. Greenberg to seek direction from the Court before releasing information.

Any letter, report or communication provided by Dr. Greenberg will only address issues related to the counseling or therapy. Such a letter does not substitute for a child custody evaluation, and Dr. Greenberg will not make any custody recommendations. Procedures in therapy are not equivalent to those provided in a child custody evaluation.

Dr. Greenberg is authorized to notify the court, with copies of the communication to counsel, if she is unable to proceed with court-ordered treatment due to non-cooperation of any party, including nonpayment of fees, or if significant obstacles are being encountered to treatment.

Dr. Greenberg requires that a minimum balance of \$1500 be maintained to cover her fees for any required or transition services.

No letters, reports, communications or testimony will be provided by Dr. Greenberg without advance payment from the parent or counsel desiring such report or testimony, or from the party responsible for paying for treatment.

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Client/Parent Initials

Attorney Initials

Absent receipt of such payment, Dr. Greenberg will be under no obligation to provide communications, testimony, or services of any kind.

I understand that if a forensic evaluator is appointed in this matter, Dr. Greenberg may be asked to provide information to this evaluator. In that event, the content of information provided to the evaluator will be at Dr. Greenberg's discretion. Both parents agree to execute any additional releases that may be necessary or convenient to document waiver of privilege.

To coordinate treatment, it may be helpful for Dr. Greenberg to communicate with other professionals (therapists, teachers, doctors, etc.). The parties hereby waive all applicable privilege to allow Dr. Greenberg to receive information from and provide any and all treatment information to the professionals listed below:

\_\_\_\_\_  
\_\_\_\_\_

The parties agree to execute any additional releases that may be necessary or convenient to allow such communication. If Dr. Greenberg believes that communication with any other professionals would be helpful to treatment, additional releases may be requested from the parties or minor's counsel. If Dr. Greenberg requests communication with the parties' individual treating therapists, the parties may provide a one-way release, preserving the confidentiality of their individual treatment information, if appropriate.

**PAYMENT RESPONSIBILITY:**

The cost of the counseling shall be paid as follows: \_\_\_\_\_ Father; \_\_\_\_\_ Mother ;  
\_\_\_\_\_ ½ by each party in accordance with the terms of Dr. Greenberg's fee agreement.

Dr. Greenberg's individual meetings with each parent will be paid for by:

\_\_\_\_\_ the parent attending the session  
\_\_\_\_\_ ½ by each party;  
\_\_\_\_\_ Father;  
\_\_\_\_\_ Mother

Missed or canceled sessions will be paid for by:

\_\_\_\_\_ the parent attending the session  
\_\_\_\_\_ ½ by each party;  
\_\_\_\_\_ Father;  
\_\_\_\_\_ Mother

Outside-session services (including but not limited to conference calls, correspondence, and telephone calls), as described in Dr. Greenberg's consent agreement, will be paid as follows:

I acknowledge that they have had an opportunity to review Dr. Greenberg's fee/consent agreement, and to consult with my attorney concerning it. I agree to abide by the terms of this agreement. Each parent and counsel acknowledge that treatment services may be suspended if fees are not paid, and that Dr. Greenberg has no responsibility to provide letters, testimony or other services if fees are not paid. If treatment services are suspended due to nonpayment of fees by either party, Dr. Greenberg is authorized to disclose this information to both parents, all counsel and the Court.

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Client/Parent Initials

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Attorney Initials

It is Dr. Greenberg's responsibility to determine the conditions under which treatment can be effective, and to withdraw from the case if she determines that her services can no longer be effective. I am responsible for complying with both the terms of this agreement and the terms of any order governing Dr. Greenberg's services.

If I have chosen to enter into this agreement without consulting counsel, I hereby acknowledge that I have had an opportunity to consult counsel and that Dr. Greenberg recommended that I do so prior to signing the agreement.

A photocopy or facsimile of this consent shall be considered as valid as the original

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Client/Parent Name

Client/Parent Signature

Date

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Attorney Name

Attorney Signature

Date