

Forms for Custody Evaluations

- Pgs 1-5: **Parent Information**-To be completed by each parent involved in the custody evaluation.
- Pg 6: **Child Information**-To be completed by each parent involved in the custody evaluation. Each parent complete one form per child involved in the custody evaluation.
- Pgs 7-8: **Additional Interviewee**-To be completed by each additional adult interviewed in the custody evaluation; you may need multiple copies of this form
- pgs 9-11: **Declaration Statement**-To be signed by each parent involved in the custody evaluation
- Pgs 12-15: **HIPAA Overview**-To be reviewed by each parent involved in the custody evaluation (this is to be kept for your records and does not need to be brought to the session)
- Pg 16: **HIPAA Acknowledgement**-To be signed by all adults attending counseling
- Pg 17: **Release of Information**-Gives consent for Dr. Belaire to interview and get records from third party individuals or organizations. One form should be completed by each parent for each of the following:
 - Court in which your case is managed (i.e. 19th JDC, etc.)
 - Parent's attorney
 - All doctors the parent has seen in the last 10 years
 - All doctors each child has seen in the last 10 years
 - All counselors each parent has seen
 - All counselors each child has seen
 - Each child's school and/or daycare
 - Anyone else Dr. Belaire needs to interview
 - Separate consent forms are needed for each family member for each professional (i.e. mother's attorney, mother's doctor, father's attorney, father's doctor, child 1's doctor, child 1's school, child 2's doctor, child 2's school, etc.). Do **not** combine multiple family members on one form. Do **not** include more than one third party individual/organization on one form. **You will need to print multiple copies of this form.**

Christine Belaire, Ph.D., LPC,
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Baton Rouge, LA 70816



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fax: (225) 291-1336
www.BelaireCounseling.com
DrBelaire@BelaireCounseling.com

Custody Evaluation Parent Intake Form

Name: _____ Age: _____ Sex: _____

Address: _____

Phone: _____ Cell: _____

E-mail: _____

Date of birth: _____ Marital status: _____

If married, list spouse name and contact information: _____

Occupation: _____ Years of Education/Degree: _____

Employer: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Attorney name: _____

Attorney address: _____

Attorney phone: _____ Fax: _____ Email: _____

Judge: _____

Court parish: _____ Suit number: _____

Date of marriage: _____ Date of divorce: _____

Describe the current custody arrangement (include visitation schedule): _____

Who is the domiciliary parent? _____

Primary physician: _____ Physician phone: _____

Physician address: _____

List any medical conditions: _____

List all current medications: _____

List any counselors that you have seen (include contact information): _____

List all other people living in your home:

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Have you been a party in a custody dispute in the past? Y N If so, give a brief description: _____

List all long-term relationships and marriages below (include children from each).

Name: _____ Date met: _____ Date of marriage: _____

Date of Separation _____ Date of Divorce: _____

Children (include current ages): _____

Name: _____ Date met: _____ Date of marriage: _____

Date of Separation _____ Date of Divorce: _____

Children (include current ages): _____

Name: _____ Date met: _____ Date of marriage: _____

Date of Separation _____ Date of Divorce: _____

Children (include current ages): _____

Name: _____ Date met: _____ Date of marriage: _____

Date of Separation _____ Date of Divorce: _____

Children (include current ages): _____

Responsible party/guarantor: _____ Social security #: _____

RELEASE/PAYMENT AUTHORIZATION: I agree to provide payment in full at the time of service to Belaire Counseling Services, LLC 5536 Superior Dr. Suite B, Baton Rouge, LA 70816. I acknowledge that I received a copy of the HIPAA Privacy Notice.

Signature

Date

For each issue below, place a check under the number to decide how much each issue has distressed, worried or bothered you in the past TWO weeks.

1 –Not at all 2 –Slightly 3 –Moderately 4 –Considerably 5 -Extremely

1	Feeling angry	1	2	3	4	5
2	Feeling timid or shy	1	2	3	4	5
3	Feeling depressed	1	2	3	4	5
4	Being easily embarrassed	1	2	3	4	5
5	Feeling like a failure	1	2	3	4	5
6	Feeling on the verge of tears	1	2	3	4	5
7	Being ill at ease with others	1	2	3	4	5
8	Feeling discouraged	1	2	3	4	5
9	Not feeling like eating	1	2	3	4	5
10	Lacking friends	1	2	3	4	5
11	Feeling shy with the opposite sex	1	2	3	4	5
12	Blaming, criticizing or condemning others	1	2	3	4	5
13	Difficulty holding conversations	1	2	3	4	5
14	Feeling hopeless	1	2	3	4	5
15	Having headaches	1	2	3	4	5
16	Difficulty sleeping	1	2	3	4	5
17	Staying by yourself a lot	1	2	3	4	5
18	Feeling tense and nervous	1	2	3	4	5
19	Upset stomach	1	2	3	4	5
20	Sexual problems	1	2	3	4	5
21	Suicidal thoughts	1	2	3	4	5
22	Problems with family	1	2	3	4	5
23	Upset by academic concerns	1	2	3	4	5
24	Problems with spouse or significant other	1	2	3	4	5
25	Stress related to work	1	2	3	4	5
26	Stress related to school	1	2	3	4	5
27	Being overweight	1	2	3	4	5
28	Problems with anxiety	1	2	3	4	5
29	Unhappy with living arrangements	1	2	3	4	5

The following are common concerns of individuals. Please check all that apply to you.

1. My family has a history of (check all that apply):

- poor communication counseling abuse
 depression hospitalization alcoholism
 eating disorders drug or gambling addiction

2. I use alcohol:

- less than once per week more than once per week never

3. I use drugs:

- less than once per week more than once per week never

4. The following have resulted from my use of alcohol/drugs (check all that apply):

- traffic violation black outs financial problems
 ruined relationship health problems work or academic problems

5. ___ I have been in trouble with the legal system.

6. ___ I have had an unwanted sexual experience.

7. I have experienced (check all that apply):

- emotional abuse sexual abuse physical abuse

8. I've tried to control my weight with (check all that apply):

- vomiting laxatives not eating
 diet pills excessive exercise other

9. I have thought or tried to (check all that apply):

- harm myself harm another person

10. At times, I have acted in a violent manner.

11. I have recently had problems with the following (check all that apply):

- sleeping appetite fatigue
 concentration weight loss/gain mood shifts
 headaches anxiety medical problems

12. I have difficulty (check all that apply):

- expressing my emotions controlling my anger handling stress
 accepting myself accepting compliments

13. I have experienced a recent (check all that apply):

- death relationship that ended major move

14. ___ Sometimes I hear unwanted voices in my head.

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Custody Evaluation Child Information

Please fill in the following information on each child involved in the legal custody dispute. You may use the back of this sheet if additional space is needed.

Parent name: _____

Child's name: _____ DOB: _____ Age: _____ Sex: _____

Grade: _____ School: _____ Teacher(s): _____

Extracurricular activities (sports, music, faith-based activities, clubs, hobbies, etc.): _____

Primary doctor name: _____

Address: _____

Phone: _____ Fax: _____

List any medical conditions: _____

List all current medications: _____

List any behavioral/emotional problems or concerns: _____

List any counselors that this child has seen (include contact information): _____

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Custody Evaluation Additional Interview Form

Name: _____ Age: _____ Sex: _____

Address: _____

Phone: _____ Cell: _____

E-mail: _____

Date of birth: _____ Marital status: _____

Occupation: _____ Years of Education/Degree: _____

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

List any medical conditions: _____

List all current medications: _____

Relationship to parties involved in custody evaluation: _____

How would you describe your role with this family? _____

Are you ever in situations where you are a caregiver for the children (without a parent present)? If yes, please

describe: _____

List all other people living in your home:

Name: _____ Age: _____ Sex: _____ Relationship: _____

Name: _____ Age: _____ Sex: _____ Relationship: _____

Name: _____ Age: _____ Sex: _____ Relationship: _____

Name: _____ Age: _____ Sex: _____ Relationship: _____

Name: _____ Age: _____ Sex: _____ Relationship: _____

Have you been a party in a custody dispute in the past? **Y** **N** If so, give a brief description:

RELEASE AUTHORIZATION: I agree to release information from the session for the purposes of the custody evaluation to Belaire Counseling Services, LLC, 5536 Superior Dr. Suite B, Baton Rouge, LA 70816.

(Signature)

(Date)

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CHILD CUSTODY EVALUATION INFORMATION & DECLARATION STATEMENT

INTRODUCTION

The information contained in this document gives a summary of the custody evaluation format, the required documents, the fee schedule and a declaration statement that must be signed in advance of the evaluation.

CUSTODY EVALUATION FORMAT

- 1) Parent #1 will attend a one-hour individual session for the purpose of the evaluator gaining insight into the history of the custody case before the court.
- 2) Parent #2 will attend a one-hour individual session for the purpose of the evaluator gaining insight into the history of the custody case before the court.
- 3) Parent #1 and the children will attend a two-hour family session. This session must include all persons who reside in the household and may also include any additional persons who play an active role in the children's lives while they are at that parent's home. This session consists of observation and interviews. It is unstructured and allows the evaluator to observe the interaction of the family members with the children in question.
- 4) Parent #2 and the children will attend a two-hour family session. This session must include all persons who reside in the household and may also include any additional persons who play an active role in the children's lives while they are at that parent's home. This session consists of observation and interviews. It is unstructured and allows the evaluator to observe the interaction of the family members with the children in question.
- 5) Parent #1 will attend a second individual interview session with the evaluator for the purpose of gathering any additional information, answering questions that the evaluator may have and reconciling conflicting information.
- 6) Parent #2 will attend a second individual interview session with the evaluator for the purpose of gathering any additional information, answering questions that the evaluator may have and reconciling conflicting information.
- 7) A final joint session will be held with both of the parents in attendance (no children). The interaction of the parties will be assessed with respect to their ability to communicate and their ability to work toward cooperative parenting. At this time the evaluator may share conclusions and recommendations. This final session is part of the evaluation, and any information in this final session will be included in the final report.
- 8) Additional sessions may be needed for larger families, interviews with grandparents and other significant parties, home visits, etc. These sessions are not part of the regular evaluation fee and will be charged according to the fee schedule.

- 9) A Custody Evaluation Report is then written and submitted to the judge and both attorneys assigned to the custody case.

REQUIRED DOCUMENTS

- 1) The Custody Evaluation Information and Declaration Statement (this form). The signature page must be signed and turned in at the first session.
- 2) The Custody Evaluation Parent Intake Form must be filled out and turned in at the first session.
- 3) A Custody Evaluation Child Information Form must be filled out on each individual child involved in the evaluation and turned in at the first session. Each parent must fill this form out on each child.
- 4) A Custody Evaluation Release of Information Form should be filled out for each of the people/places listed below:
 - a. Parents
 - i. Attorney(s)
 - ii. Doctor(s) seen in the last five years
 - iii. Mental health professional(s) seen in the last five years
 - iv. Anyone else you want Dr. Belaire to talk to or anyone else Dr. Belaire deems necessary
 - b. Each Child
 - i. Doctor(s) seen in the last five years
 - ii. Mental health professional(s) seen in the last five years
 - iii. School(s) attended in the last five years
 - iv. Daycare(s)/Sitters for the last five years
 - v. Anyone else you want Dr. Belaire to talk to or anyone else Dr. Belaire deems necessary
- 5) Copies of any legal documents, records, reports, orders or pleadings. This should include those related to separation, divorce, custody, etc.
- 6) Any additional documents or items that the evaluator may need to see or hear.

FEE SCHEDULE

Responsibility for payment is expected to be split between each of the parents unless other arrangements are made prior to the start of the evaluation or a court order is issued specifying payment amounts. If a court order is issued concerning payment, a copy of the signed order must be submitted for the custody evaluation records at Belaire Counseling Services.

Each party is expected to pay his/her portion through one of the following two methods:

- 1) The custody evaluation fee may be paid in full in advance by cash or check. If a parent chooses to pay using this method, he or she will receive a 10% discount on his or her portion of the fee.
- 2) The custody evaluation fee may be paid over the course of the evaluation by making payments at each session with payment in full due by the last session.

Any cancellation with less than 24 hours notice or a failure to show will be billed at the regular hourly rate of \$150.00/hour and must be satisfied before another session can be scheduled. A \$35.00 NSF fee will be applied to any returned checks.

→ All financial obligations must be completed before a report will be written.

Service	Fee	Notes
Custody Evaluation	\$3000.00	Includes sessions listed above and the written report
Additional hours for written report for court	\$150.00 / hour	
Home Visits	\$400.00 / visit	A visit is for up to 2 hours; mileage will be charged for distances greater than 20 miles
Court appearance	\$1000.00 / day	To be paid one week in advance
Depositions	\$200.00 / hour	2 hour minimum paid one week in advance; payment for additional hours to be paid in full at the end of the deposition.
Additional sessions	\$150.00 / hour	

Note: Additional court and deposition hours are charged from the start of the hour and are not prorated.

CONFIDENTIALITY

I agree to pay in full the custody evaluation fee as well as any additional charges incurred. **I understand that the custody evaluation report will not be generated until my account is settled.** I understand that any cancellation with less than 24 hours notice or a failure to show up for a session will be billed at the regular hourly rate and must be satisfied before another session can be scheduled. In addition, I understand that in court-ordered evaluations, the traditional doctor-patient confidentiality requirements are not applicable and any information or data that is presented in the evaluation may be made available to the court and/or included in the custody evaluation report.

I have read, understand, and accept the terms listed above:

Signature

Date

Your Information ■ Your Rights ■ Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective 01/01/2014
- Christine Belaire, Privacy Officer, drbelaire@belairecounseling.com, (225) 291-1335
- We never market or sell personal information. We do not keep or give information for any hospital's directory. We do not use personal information for the raising of funds.
- We may not comply with a subpoena unless it is accompanied by a separate written order issued by a judge authorizing disclosure of information or issuance of the subpoena. The patient/client has the right to take legal action to restrain the release of records.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Belaire Counseling Services, LLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. Our Notice of Privacy Practices is subject to change.

Signature of Patient /Patient Representative

Date

Name of Patient/ Patient Representative (please print)

Relationship to Patient

COMPANY USE ONLY:

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

- Patient Refused to Sign
- Patient Representative Refused to Sign
- Emergency Situation Prevented Signature
- Other (please specify)

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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION AND RECORDS FOR CUSTODY EVALUATION

Pursuant to Federal Guidelines concerning my right to confidentiality, I

Name: _____ **DOB:** _____

Authorize: **Dr. Christine Belaire**
Belaire Counseling Services, LLC
5536 Superior Drive Suite B
Baton Rouge, LA 70816

To release/exchange/receive/discuss information about the following person(s):

Name: _____ **DOB:** _____

Concerning/related to (check all that apply):

- Psychological records Psychotherapy notes Medical records
- Legal records Social records Pharmacy records
- Phone records Financial records Payment
- Comprehensive Childcare/School File Other:

With the following person(s)/organization (name, address, phone number):

I understand that I may revoke this consent to the release of information in writing at any time and that this consent will expire no later than six (6) months from the end of the custody evaluation. I further understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality.

(Signature) (Date)