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Belaire
Counseling Services

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Custody Evaluation Forms

- Pages 2-7: **Parent Information Form**
  To be completed by **each** parent involved in the custody evaluation

- Page 8: **Child Information Form**
  To be completed by each parent involved in the custody evaluation. Each parent must complete one form per child involved in the custody evaluation

- Pages 9-10: **Additional Interview Form**
  To be completed by each additional adult interviewed in the custody evaluation; you may need multiple copies of this form

- Pages 11-15: **Declaration of Practices and Procedures**
  To be signed and initialed by **all** adults attending counseling

- Page 15: **HIPAA Acknowledgement of Receipt of Notice of Privacy Practices**
  To be signed by **all** adults attending counseling

- Pages 16-21: **HIPAA Notice of Privacy Practices**
  To be reviewed by **all** adults attending counseling. **NOTE: This is to be kept for your records and does not need to be brought to the counseling session**

- Page 22: **Consent and authorization to release information and records for custody evaluation or court related counseling**
  Gives consent for Dr. Belaire to interview and get records from third party individuals or organizations. Separate consent forms are needed for each family member for each professional listed below. 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.** One form should be completed by each parent for each of the following:
  - Court in which your case is managed
  - Parent's attorney
  - All doctors each 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/daycare
  - Anyone else Dr. Belaire needs to interview

Parent Information Form

Name: _____ DOB: _____ Age: ____ Sex: ____

Phone: _____ Email: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____

Years of Education/Degree: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

(if applicable)

Current Spouse Name: _____ DOB: _____ Age: ____ Sex: ____

Phone: _____ Email: _____

Children From Past Relationships (include current ages): _____

_____

Attorney Name: _____ Company: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: _____ Fax: _____

Judge: _____

Court Parish: _____ Suit Number: _____

Name: _____

(Relationship in custody dispute)

Date of Marriage: _____ Date of Divorce: _____

Current Custody Schedule: _____

_____

_____

Domiciliary Parent: _____

Primary Doctor's Name: _____ Company: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: _____ Fax: _____

List any medical conditions: _____

_____

List all current medications: _____

_____

_____

List any counselors/mental health professionals that this you have seen in the last ten years (including contact information):

_____

_____

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

_____

_____

Name: _____

List all 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: _____

List all marriages and long-term relationships below (including the one in the custody dispute):

Name: _____ Children (Include current ages): _____

_____

Date of Relationship Start: _____ Date of Separation: _____

Date of Marriage: _____ Date of Divorce: _____

Name: _____ Children (Include current ages): _____

_____

Date of Relationship Start: _____ Date of Separation: _____

Date of Marriage: _____ Date of Divorce: _____

Name: _____ Children (Include current ages): _____

_____

Date of Relationship Start: _____ Date of Separation: _____

Date of Marriage: _____ Date of Divorce: _____

Name: _____

For each issue below, mark each number to indicate how much each issue has distresses, 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	Difficulty sleeping	1	2	3	4	5
16	Staying by yourself a lot	1	2	3	4	5
17	Feeling tense and nervous	1	2	3	4	5
18	Upset stomach	1	2	3	4	5
19	Sexual problems	1	2	3	4	5
20	Suicidal thoughts	1	2	3	4	5
21	Problems with family	1	2	3	4	5
22	Upset by academic concerns	1	2	3	4	5
23	Problems with spouse or significant other	1	2	3	4	5
24	Having headaches	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

Name: _____

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

1. **My family has a history of:**

__ Poor communication
__ Depression
__ Eating disorders
__ Counseling
__ Hospitalization
__ Drug or gambling addiction
__ Abuse
__ Alcoholism

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:**

__ Traffic violation
__ Ruined relationship
__ Blackouts
__ Health problems
__ Financial problems
__ Work or academic problems

5. **I have been in trouble with the legal system.** **Y** **N**
6. **I have had an unwanted sexual experience.** **Y** **N**
7. **I have experienced:**

__ Emotional abuse
__ Sexual abuse
__ Physical abuse

8. **I've tried to control my weight with:**

__ Vomiting
__ Laxatives
__ Diet pills
__ Excessive Exercise
__ Not eating
__ Other

9. **I have thought of or tried to:**

__ Harm myself
__ Harm another person

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

Name: _____

11. **I have recently had problems with the following:**

__ Sleeping
__ Concentration
__ Headaches
__ Appetite
__ Weight loss/gain

__ Anxiety __Mood shifts

__ Fatigue __ Medical problems

12. I have difficulty:

__ Expressing my emotions __ Controlling my anger

__ accepting myself __ Accepting compliments

__ Handling stress

13. I have experienced a recent:

__ Death __ Relationship that ended __ Major move

14. Sometimes I hear unwanted voices in my head. Y N

Print Name: _____ Signature: _____

Date: _____

Child Information Form

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 Names: _____

Child's Name: _____ DOB: _____ Age: ____ Sex: ____

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

_____

Extracurricular Activities/Hobbies: _____

_____

_____

Primary Doctor's Name: _____ Company: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: _____ Fax: _____

List any medical conditions: _____

_____

List all current medications: _____

_____

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

_____

List any behavioral/emotional problems or concerns: _____

_____

Additional Interview Form

Name: _____ DOB: _____ Age: ____ Sex: ____

Street Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____

Phone: _____ Email: _____

Years of Education/Degree: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____

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? If so, give a brief description:

_____

_____

_____

_____

_____

RELEASE AUTHORIZATION: I agree to release information from the session for the purpose of the custody evaluation to Belaire Counseling Services, LLC.

Signature: _____ Date: _____

Declaration Statement

Christine Belaire, Ph.D.

LPC-S[1] #2770, LMFT[2] #534

National Certified Counselor (NCC)

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Baton Rouge, LA 70816

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DrBelaire@BelaireCounseling.com

www.BelaireCounseling.com

Education:

Ph.D., Mississippi State University, 2001

Major: Counselor Education, Community Counseling

MA, Louisiana State University, 1998

Major: Counselor Education, Agency Counseling

Areas of Expertise:

Marriage and Family, Depression/Anxiety, Play Therapy, Custody Evaluations, Parenting Disputes, Parenting Education, Women's issues, and Spirituality.

[1]Licensed Professional Counselor Board of Examiners

14410 Lake Sherwood Ave. N., Ste. A
Baton Rouge, LA 70816
Phone: 225-295-8444

[2]Licensed Professional Counselor Board of Examiner (licensing board for Marriage and Family Therapists)

14410 Lake Sherwood Ave. N., Ste. A
Baton Rouge, LA 70816
Phone: 225-295-8444

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 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, interviews with grandparents and other significant parties, home visits, etc. may be needed for larger families. 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 for each individual child involved in the evaluation and turned in at the first session. Each parent must fill out this form for each child.

4) A Custody Evaluation Release of Information Form should be filled out for each of the people/places listed below. Use one form for each professional per person. You will many copies of this form.
    a. Parents
        i. Attorney(s)
        ii. Doctors(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. Doctors(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/she will receive a 10% discount on his/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 cancelation with less than 24-hour 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 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	$4,000.00	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	$1,000.00/day	To be aid 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-hour 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 ae 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.

Print Name: _____ Signature: _____

Date: _____

HIPAA
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 Date

Patient #1 or Patient Representative

_____ _____

Print Name Relationship to Patient

Patient #1 or Patient Representative If Representative

_____ _____

Signature Date

Patient #2 or Patient Representative

_____ _____

Print Name Relationship to Patient

Patient #2 or Patient Representative If Representative

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 or Representative Refused to Sign
- ☐ Emergency Situation Prevented Signature
- ☐ Other (Please Specify): _____

HIPAA Notice of Privacy Practices

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**.

Contents

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 a copy of your paper or electronic 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.

Correct your paper or electronic 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 communication

- 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 the information we 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 as 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 have shared your 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, with whom we have shared it, and why.
- We will include all the disclosures except for those about treatment, payment, 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 believe your privacy rights have been 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 Ave., 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 w3hat 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.jjs.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 website.

Other Instructions for Notice

- Effective 01/01/2014
- 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.

Christine Belaire, Ph.D.
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Belaire
Counseling Services

Phone: (225)291-1335
Fax: (225)291-1336
5536 Superior Dr., Ste B.
Baton Rouge, LA 70816

Consent and authorization to release information and records for custody evaluation or court related counseling

Pursuant to Federal Guidelines concerning my right to confidentiality, I,

Name: _____ DOB: _____

Authorize: Dr. Christine Belaire
Belaire Counseling Services, LLC

To release, exchange, receive, and discuss information about:

Name: _____ DOB: _____

Concerning/related to (Check all that apply):

☐ Psychological Records	☐ Psychotherapy Notes	☐ Pharmacy Records
☐ Legal Records	☐ Social Records	☐ Billing/Payment
☐ Phone Records	☐ Financial Records	☐ Other: _____
☐ Educational Records	☐ Medical Records	_____

With the following person(s)/organization:

Name: _____ Fax: _____

Company: _____ Email: _____

Phone: _____ Address: _____

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 was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality.

Signature: _____ Date: _____