| Elazar Bloom, M.A., LMFT2699 Stirling Road Suite C403EFort Lauderdale, FL. 33312(754) 600-9040 EB@ElazarBloom.com |  |  |  |
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**Separated/Divorced Parents’ Agreement Form**

I have brought my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, age \_\_\_\_\_\_\_, to Elazar Bloom, LMFT, for evaluation and/or treatment. I understand that Mr. Bloom’s client is my child – not me, any other sibling, or my spouse. This is true no matter who pays Mr. Bloom for the evaluation/treatment of my child.

I understand that Mr. Bloom’s primary responsibility is my child’s best interest and that Mr. Bloom may decide to involve me in my child’s evaluation/treatment at her sole discretion. I understand that if payment is not received promptly for services rendered by Mr. Bloom to my child, the services may be suspended or terminated at Mr. Bloom’s sole discretion, pursuant to the ethical guidelines governing mental health care.

I understand that Mr. Bloom is not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than my child at any deposition, court proceeding, or in any other way. I understand that Mr. Bloom may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at her sole discretion. Mr. Bloom may also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court or counsel for my child.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_