R. PHILLIP COLON, Ph.D.

520 Franklin Avenue, Suite 215
Garden City, New York 11530
516/294-8914

I, _____ do willingly agree to enter and participate in counseling with my wife/husband, _____, under the clinical care of R. Phillip Colon, Ph.D. I also agree that myself or any of my legal representative(s) will not subpoena Dr. R. Phillip Colon to testify in court or in any part of legal proceedings involving material disclosed as a result of counseling sessions nor ask for a statement or report (verbal or written) of said material from Dr. Colon.

This agreement is binding whether or not there is a legal dissolution of the marital relationship. This agreement is binding after either myself and/or my spouse terminate treatment with Dr. Colon.

The purpose of this document is to create and preserve a counseling environment where parties concerned can feel free to participate and disclose; knowing that what is divulged will not be used against them in a court of law.

_____

Signature:

_____

Print name being signed:

Date