PARENTAL RESPONSIBILITIES/PARENTING TIME EVALUATION

_____ Last Name, First, Middle Initial ___/___/___ Birth Date _____ Social Security Number

_____ Address City State Zip Code

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

E-mail: _____

Name of Employer _____ Phone: ( ) _____

Name of Attorney _____ Phone: ( ) _____

Attorney's E-mail: _____

CONTRACT OF SERVICE

I agree to abide by the procedures outlined in the "Parental Responsibilities/Parenting Time Evaluation Agreement." I have also reviewed and agree to policies covered in the following documents: "To My Clients," "Policy as Regards Release of Psychological Test Data," "Policy for Court Appearances," and "Policy for Home Visits." I understand that preparation for and testimony in court is billed separately from other evaluation charges.

I understand $8,000.00 is due at the start of the evaluation. I am responsible for (all, or if a percentage, specify the amount) _____. If the evaluation is terminated before the final report is issued, I understand I will be responsible for $750.00 plus any charges (or my proportional responsibility) that have been made up to that point. All evaluation work (except court testimony – see separate policy for court appearance) will be billed at $250.00 an hour (50 minutes). Evaluation costs generally range from $10,000.00 to $ 20,000.00. Each case is unique and it is difficult to determine the total cost at the outset of the evaluation. We will discuss our best estimate once we understand the scope of the evaluation. Some of the tasks that can add additional costs are: Assessing a child's relationship with an extended family member; reviewing extensive documents from protracted litigation or medical/psychological treatment; home visits and the associated travel time.

I understand that the costs of the evaluation must be paid in full before the evaluation report is released. I also understand that final payment is due by **certified check**. My responsibility for payment of the evaluation costs, after the initial $8,000.00, is _____ .

If, for some reason, my bill is not paid in full, the following policies will apply. Any unpaid balance that is not received within 60 days after the date of billing will accrue a monthly late charge of 1.5% of the unpaid balance. If you do not pay outstanding fees, we will request a judgment, file a contempt citation, or make use of a collection agency and you will be responsible for any fees we, or our attorney, incur in pursuit of payment. This includes costs for legal representation and appearance at court hearings.

Client Signature: _____ Date: _____

(You will receive monthly statements with cumulative charges and payments. You may also request statements from my office manager, Sandi Frye, at other intervals. The final statement will include an administrative fee of $200 and a charge of 1 - 2 hours for report review by a colleague.)