Comprehensive Psychoeducational Assessment

ADMINISTRATIVE POLICIES AND FEES

SERVICES AND FEES

Comprehensive Psychoeducational Assessment: includes a parent interview and discussions, review and synthesis of background material, screening for social, emotional and behavioral issues, assessment of the cognitive processing abilities and skills that affect learning and school performance, assessment of academic skills in reading, writing, mathematics and oral language, interests and strengths assessment, and a written report detailing the student's profile of learning strengths and areas of vulnerability with recommendations. Findings are discussed at a parent feedback meeting and a separate follow-up meeting with the student.

Fee: $8,000

Families who wish to schedule an assessment are requested to provide 50% payment ($4,000) in advance to reserve the first assessment appointment. The balance ($4,000) of the total fee is due upon scheduling the parent feedback session.

For a reasonable period of time after an assessment has been completed, I will continue to make myself available to answer questions and help parents implement recommendations without additional charge. Families who wish to continue to consult beyond this period of time will be asked if they wish to do so on an hourly fee basis. The hourly rate is $350. Consultations are charged in 15-minute unit blocks at the rate of $75 per unit block. Lengthy e-mail communications will be billed in the same manner. Consultations with other treatment providers (e.g., therapists, executive function coaches, advocates) will be billed based at the same rate. Classroom visits to observe the student, visits or phone conversations with teachers or school administrators, attendance at PPT or IEP meetings, etc. will be billed at the hourly rate.

BILLING AND PAYMENTS

Cash, checks, and credit card payments are accepted. Receipts will be provided if requested.

CANCELLATIONS

Because appointments are generally scheduled months in advance, if you must cancel or reschedule, please do so as far in advance as possible so I can attempt to schedule another student for the time slot we had scheduled for your child. I check my e-mail regularly, and every attempt will be made to reschedule your child for another date.

Cancellation of other appointments (e.g. school meetings) requires 24-hour's notice. Otherwise, I will have to charge the full estimated fee at my hourly rate for my intended attendance at the appointment.

INSURANCE REIMBURSEMENT

Although some insurance companies will cover the cost of a psychoeducational assessment, families are advised that full reimbursement cannot be expected in most cases. It is best to enter into the assessment process with the expectation that the family will be responsible for payment in full. Upon request I will provide an invoice for you to submit a claim to your insurance company. If your insurance company requests additional information from me, I must bill for the time it takes me at my hourly rate as appeals can be very time consuming.

LEGAL INVOLVEMENT

I understand that if Dr. MacEachron (the psychologist), is required to, is requested to, or agrees to, be involved in a legal matter concerning me or my child(ren), then I will be responsible to compensate her for all of her time expended. I understand that any health insurance benefits I may have do not cover the time or services of psychologists spent on patients' legal involvements. I agree that her fee for case preparation, record review, telephone calls, correspondence,

conferences, written reports, any testimony and consultations with lawyers, including her own lawyer, or other court personnel, will be calculated at the rate of $350 per hour.

Fees for all of the above activities will be payable in advance of any of those activities and will be based on the psychologist's estimate of the time that will be necessary for them. Any overpayment of fees will be refunded to me within 10 days of when the psychologist is notified that the legal matter has been finally settled or it otherwise becomes certain, as determined at the sole discretion of the psychologist, that it will not be necessary for the psychologist to spend additional time on legal involvement in the case. The psychologist may request, and I will pay, additional amounts if the original amount turns out to be an underestimate of the actual amount needed.

Fees for any testimony will be payable at least 2 weeks in advance of the date scheduled and will be based on the psychologist's estimate of the time for testimony and the time traveling to and from the place where the testimony will be given. The actual fee will be computed from the time the psychologist arrives at the place where testimony is to be given until the time the psychologist is dismissed, plus travel time to and from the place of testimony from the psychologist's office. Any adjustments from the estimate will be made after all testimony of the psychologist has been completed.

I understand that if, after the psychologist's testimony is scheduled, it is postponed or canceled for any reason and the psychologist cannot be notified at least 1 week in advance, then a fee of $750 will be charged to reimburse the psychologist for time set aside for the testimony.

I agree to pay photocopying charges of $.75/page for copies of any records or reports that the psychologist is requested or required to produce, including by subpoena.

I agree that my obligation to compensate the psychologist as stated above will be the same whether I or any other party involved in any legal matter request or require the psychologist’s involvement or testimony, and agree that my obligation to pay the psychologist as stated in this agreement will not be affected by the service of any subpoena on the psychologist.

I understand that my paying the psychologist for time for legal involvement does not mean that the psychologist will be qualified as or will serve as an expert witness, nor does it mean that the psychologist's involvement will be of help to me in any legal action. This agreement will continue in existence and continue to be binding on me even after my treatment with the psychologist ends. This agreement will be enforceable in court.

CONFIDENTIALITY

Because I do not take insurance, I am not required to meet all confidentiality rules provided in the Health Insurance Portability and Accountability Act (HIPAA).

If I learn of child abuse, neglect, or other serious threats of harm to a child, I may take protective action. I am ethically permitted to release information to prevent potential acts of suicide. If you or your child are required to testify about your case in a court of law I may be required to testify and compelled to respond to an irrevocable court order. Finally, if you file a complaint or lawsuit against me I may need to disclose information in our defense.

I have read, understood and agree to abide by the above policies and fee schedule. If I am consenting to this evaluation on behalf of my minor child, I hereby state that I have the proper legal status to give such consent.

Signature _____

Relationship to Child if a minor _____

Date _____