

Consultation

ADMINISTRATIVE POLICIES AND FEES

SERVICES AND FEES

Consultation: I am available to discuss your family's situation and do anything I can to help over the phone, by e-mail, or in person.

Hourly Rate: \$350

Families who wish to schedule a consultation are requested to sign this agreement in advance and will be asked to provide a credit card for billing purposes at the beginning of the scheduled consultation.

The hourly rate is \$350. Consultations are charged in 15-minute unit blocks at the rate of \$87.50 per unit block. E-mail communications will be billed in the same manner. Time spent reviewing any provided background data will also be billed at the hourly rate.

BILLING AND PAYMENTS

Credit card payments are the easiest way to handle this type of service.

CANCELLATIONS

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

INSURANCE REIMBURSEMENT

I do not take insurance, and insurance would not cover a consultation of the type I do in any event.

CONFIDENTIALITY

The information that you share with me is protected under confidentiality rules found in the codes of ethics of the American Psychological Association and the laws of the State of New York and your home state.

There are, however, some exceptions. I may thank any referral source who recommended me to you. 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 my defense.

I have read, understood and agree to abide by the above policies and fee schedule.

Signature _____

Relationship to child if a minor _____

Date _____

OPTIONAL E-MAIL RELEASE

Many families find it convenient to discuss aspects of their child via e-mail or other communication means that may not be completely secure from a privacy standpoint. Families may also wish to receive a copy of their child's completed report in the form of an e-mail attachment. In those events, I will need you to fill out and sign the additional disclaimer below.

I have been informed of the risks, including but not limited to loss of confidentiality, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive these services. I also understand that I may terminate this authorization at any time in writing to the extent that Devon MacEachron, PhD has not already relied upon it. I understand that Devon MacEachron, PhD makes available to me the other means of communication (phone conversations, in-person meetings, mailing reports and communication by non-electronic means) that are designed to be more secure and to maintain confidentiality, and I still choose to request and authorize the above-named less secure means.

Signature _____

Date: _____