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TYSON D BAILEY, PSYD

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FEE AGREEMENT FOR PSYCHOLOGICAL EXPERT WITNESS WORK

This document constitutes a contract between Tyson D Bailey, PsyD of Spectrum Behavioral Health and the undersigned law firm or individual attorney for services performed by Dr. Bailey in the matter entitled:

_____

I/We agree to prompt payment of Dr. Bailey's bills for him work performed according to the following fee schedule:

I. For work of a non-testimonial nature, including but not limited to psychological evaluations, written or oral reports, consultations with attorneys or their agents, review of records, and any travel pursuant to the above, the fee will be $300.00 per hour or portion thereof. Appointments missed without cancellation will be billed at the usual rate.

II. For work of a testimonial nature, including travel to the site at which testimony shall be given and any time spent waiting to give testimony, the fee will be $350.00 per hour or portion thereof.

III. For any work requiring travel outside of King, Pierce, or Snohomish counties, Washington, reasonable travel costs will be reimbursed. A day rate of 2200.00 will be charged in lieu of the hourly fee for time spent of less than eight hours.

IV. Costs for materials, photocopying, duplication of tapes and other costs incidental to the performance of work that the client requests will be charged separately and are the client's responsibility.

MY TRAINING AND LICENSURE

I received a Doctorate of Psychology (PsyD) in Clinical Psychology from Argosy University/Seattle in 2011. I completed my predoctoral internship at the Fremont Community Therapy Project and Ryther Child Center in Seattle, WA, where I conducted numerous assessments and supervised other students on their clinical work. I am a Licensed Psychologist in Washington Sate (PY60252354). I record all sessions to ensure the accuracy of interview and other information gained throughout the assessment process.

CLIENT CONSENT TO ASSESSMENT

I understand that I, an individual attorney, or we, this law firm, constitute Dr. Bailey's client and hold direct responsibility for payment of bills to him. I understand that any arrangements that I make with my client to obtain funds for my payments to Dr. Bailey are independent of this agreement. I will not ask Dr. Bailey to enter into fee agreements with any other parties,

including my client, to satisfy my indebtedness to him. I understand that Dr. Bailey cannot bill for him work on a contingent fee basis.

I understand that any bills in arrears at the end of the calendar month will be charged a late fee of 1.5% per month. I understand that any bills in arrears for more than three months may be sent to collection at Dr. Bailey's discretion. If this becomes necessary, I understand that I will also be responsible for any additional costs incurred by Dr. Bailey in order to collect fees due. I understand that Dr. Bailey may decline to do further work on any matter where the bill is more than three months past due until payment has been made.

In the event that litigation is necessary to enforce this agreement the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. Venue shall be in Snohomish County, Washington.

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I agree have my client participate in the assessment process as described above with Tyson D Bailey, Psy.D.

Signed_____Date_____

Printed Name_____

For (Name of firm)_____

Address_____

_____

Phone_____

Fax_____