**Tikunim Counseling Services, PLLC**

AGREEMENT REGARDING MENTAL HEALTH

EVALUATION FOR THE BENEFIT OF

A THIRD PARTY

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of third party) agrees that Mr. Gavriel Fagin, LCSW, Director of Tikunim Counseling Services, PLLC and/or a designated associated of Tikunim Counseling Services, PLLC, will conduct a mental health and/or psychosexual evaluation of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “examinee”) for our benefit in a pending matter.
2. We hereby retain and agree to pay Tikunim Counseling Services, PLLC in full for services in conducting said evaluation. We acknowledge that the examinee WILL NOT become a patient of any clinician at Tikunim Counseling Services, PLLC, nor will any clinician of Tikunim Counseling Services, PLLC advise or treat the examinee in any way.
3. The fee for said evaluation is payable in advance in the amount of $\_\_\_\_\_\_\_\_. Additional expenses that can be expected in this particular evaluation, which are payable directly to an outside entity, include:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The material contained in the evaluation and a written report of the results will be sent to us by Tikunim Counseling Services, PLLC following completion of the evaluation. Tikunim Counseling Services, PLLC will not provide the examinee with any report, written or oral, of the results of the examination. We may provide the written reports to other parties, but in doing so, shall not violate any law or regulation regarding privacy, confidentiality, or privilege. If we require follow-up oral reports, telephone, or other conferences with Tikunim Counseling Services, PLLC, then we agree to pay for such contacts at the rate of $\_\_\_\_\_\_\_\_\_ per hour, as billed by Tikunim Counseling Services, PLLC.
2. We may request that a clinician at Tikunim Counseling Services, PLLC testify at a deposition or trial regarding the evaluation of the examinee. The rate for said testimony is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per hour, or $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per day, as agreed upon at the outset of this testimony. Time scheduled that is not canceled without 48 hour prior notice will be billed at the hourly rate. Further, we agree to pay Tikunim Counseling Services, PLLC for **ANY** testimony that might be required as a result of the evaluation of the examinee, and regardless of whether Tikunim Counseling Services, PLLC is subpoenaed by us **OR ANOTHER PARTY** in any related legal matter. The rates for said testimony are as stated above.

I, the undersigned, understand and agree to the above stipulations.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name and position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_