Contract for District Authorized Independent Educational Evaluation (IEE)

This agreement is between **Name of District** and Margaret J. Kay, Ed.D. NCSP, DABPS and Loura Selfe Keepers, MA, JD, NCSP, doing business as Independent Educational Evaluators of America, LLC.

The **Name of District School District** hereby authorizes *Margaret J. Kay, Ed.D. NCSP, DABPS* and *Loura Keepers, MA School Psychologist & Certified Applied Behavior Analyst* to complete an Independent Educational Evaluation (IEE) for **Name of Student**.

The **Name of District** School District agrees to be responsible for payment of all professional service fees accrued in connection with completion of the Independent Educational Evaluation (IEE). The cost of the evaluation, to include testing time, scoring, analysis and written report preparation, will be billed at a rate of **$175/hou**r and will not exceed **$2750.00**. ***Initial YES________ or NO __________ for IEE.***

If the school district requires an on-site classroom observation as part of the IEE, it will be billed at a rate **$200/hour** (observation and travel time) and will not exceed a total cost of **$1000.00** over and above the cost of the evaluation. Mileage will also be charged at the current rate approved by the IRS.
Initial YES_______ or NO ________ for observation.

If the district approves a one-hour consultation with the parent(s) and district personnel to present and discuss test findings, an additional **$175.00** will be added to the total cost of the evaluation.
Initial YES_______ or NO ________ for report consultation.

Extraneous costs for additional classroom observations and testing, phone consultations, school meetings, and expert witness testimony in legal proceedings will be billed over and above the cost of the evaluation. These additional charges would only be billed upon the receipt of prior written approval from the district.

The undersigned person, as a representative of the **Name of District School District,** affirms that the **Name of District School District** will pay for professional psychological services at the rates outlined above. Failure to pay within 30 days after services have been rendered will result in a finance charge on the total balance.

SIGNED: ____ DATE: ______________________

Witness: ____ Date: ________________________