**MICHEAL KANE, PSY.D.**
DIPLOMATE IN CLINICAL SOCIAL WORK
2711 E. MADISON STREET, SUITE 206
SEATTLE, WA 98112
(206) 723-8448
MKANEASSOC@COMCAST.NET

# FEE AGREEMENT FOR PSYCHOLOGICAL EXPERT WITNESS WORK

***This document constitutes a contract between Micheal Kane, Psy.D. and the undersigned law firm or individual attorney for services performed by Dr. Kane in the matter entitled:***

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I/We agree to prompt payment of Dr. Kane's bills for his 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 of their agents, review of records and any travel pursuant to the above, the fee will be $400/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 anytime spent waiting to give testimony, the fee will be $400/hour or portion thereof.

III. For any work requiring travel outside of King, Pierce or Snohomish Counties, WA, reasonable travel costs will be reimbursed. A rate of $4,000/day will be charged in lieu of the hourly fee for time spent of less than eight (8) 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.

***I understand that I, an individual attorney, or we, this law firm, constitute Dr. Kane'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. Kane are independent of this agreement. I will not ask Dr. Kane to enter into fee agreements with any other parties, including my client, to satisfy my indebtedness to him. I understand that Dr. Kane cannot bill for his 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. Kane's discretion. If this becomes necessary, I understand that I will also be responsible for any additional costs incurred by Dr. Kane in order to collect fees due. I understand that Dr. Kane may decline to do further work on any matter when the bill is more than three months past due until payment has been made.***

***I understand and agree that any legal action arising under or related to this agreement shall be brought and maintained exclusively in a State court of the State of Washington and the parties hereby submit themselves to the personal jurisdiction and venue of Thurston County, Washington.***

**LEGAL ACTION CLAUSE**
***In the event of default of payment and/or failure to pay, I agree to pay the costs of collection, including court costs and reasonable attorney fees to be determined by a court of law.***

Signed: _____ Date: _____

For (Name of Firm): _____ Phone: _____

Address: _____ Fax: _____