

**NORTHERN**  
**MICHIGAN PSYCHIATRIC SERVICES, P.C.**

3287-A Racquet Club Drive  
Traverse City, MI 49684

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Ethan Weckstein, D.O.  
Lynda Key, L.M.S.W.  
Sarah Rademacher, L.M.S.W.

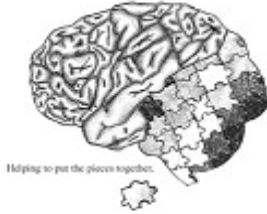
Dear prospective patient:

Attached you will find a forensic services and fee form. The Clinicians at Northern Michigan Psychiatric Services P.C. provide clinical evaluations and clinical treatment for children, adolescents and adults with neuropsychiatric disorders. They do not typically provide forensic evaluations (evaluations for legal purposes, reports to the court, testifying in court, depositions, etc.). If a clinician from Northern Michigan Psychiatric Services P.C. is asked to be involved in forensic services the attached fees will apply.

Please sign the enclosed form documenting that you are aware of this policy as well as the fees involved if forensic services are required.

Sincerely,

Sander Weckstein, M.D., F.A.P.A., F.A.A.C.A.P.  
*Diplomat, American Board of Psychiatry and Neurology  
in Child, Adolescent and General Psychiatry*



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**FORENSIC SERVICES AND FEES**

I understand that my insurance does not cover forensic services (evaluations for legal purposes, reports to the court, testifying in court, depositions, et cetera), and I realize that I am fully responsible for the payment of these services directly to Northern Michigan Psychiatric Services, P.C. My clinician will inform me if he/she feels that his involvement in legal proceedings is clinically contraindicated and, if so informed, I will do my best to facilitate that he/she is not involved in this type of process in the best interest of my child.

Northern Michigan Psychiatric Services' standard forensic fees are:

- (1) \$800.00 per hour for depositions (including preparation time, telephone calls and contact with attorneys).
- (2) \$1000.00 per hour for testimony in court (including preparation time, travel time to and from court, communication to and from attorneys, and all time lost from the office).
- (3) A retainer fee for five (5) hours of service must be received by certified check in advance of any forensic services.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/Parent Signature (if appropriate)

\_\_\_\_\_  
Date