



February 20, 2020

Dear Parents,

Thank you for your interest in learning more about my services as an educational advocate. As you know, education is the key to opportunity. Our children learn just as much about themselves in a classroom as they do about math, science, and reading. So, parents' expertise about their children is just as important as the expertise of the educators who teach them.

Children who qualify for special education services receive a large team of specialists. Unfortunately, the larger the team gets, the more parents' voices are diminished. That can be overwhelming and unnerving. The goal of our work together is to empower you to lead your child's team and assert your rights and the rights of your child. We will learn how to successfully collaborate with the school district with the least amount of conflict possible.

ADVOCATE RESPONSIBILITIES - In order to accomplish your goals, you will have my expert opinions and strategies based on 15 years in the classroom and 10 years as a nationally board certified professional counselor in the service of children and families. You will receive the following services billed at the rate below:

- Analysis of all past and current testing from psychologists, speech pathologists, occupational therapists, etc.
- Collaboration and consultation with all past and current professionals who have worked with your child
- Completion of a 90-minute observational intake session with you and your child
- Role play aspects of an IEP meeting
- Creation of realistic, contextual goals for your child's IEP
- Attendance at any IEP meetings until a plan is agreed upon to YOUR satisfaction
- In person, phone, or Skype/Zoom counseling sessions
- Travel time in excess of 30 minutes

FEES & PAYMENT – Educational advocacy fees are based on a rate of \$XXX per hour for services associated with all aspects of the case. Travel expenses incurred by me are included in the hourly rate unless otherwise specified. There is never a charge for short telephone "check-in" or scheduling coordination. The two options available are stated below. Payment can be either in the form of a check made payable to "LiveNLearn, LLC" or Zelle sent to amy@livenlearnconsulting.com. Returned checks may require additional charges and/or payment in cash. Please choose the option that best suits your preferences.

ADDRESS

PHONE

WEB

620 Sycamore Lane, Grayslake, IL 60030

847-226-6213

www.livenlearnconsulting.com



Retainer: A retainer fee in the amount of \$X,XXX is due before services begin. A detailed statement of charges will be maintained and a bi-monthly statement of charges provided to the client. Client is entitled to a copy of a statement of charges at any time. **Any unbilled portion of the retainer fee remaining at the end of the case will be refunded in full.**

Pay-As-You-Go: If the client would prefer a pay-as-you-go option, payment is due upon receipt of the bi-monthly statement unless otherwise arranged. Clients are permitted to pay partial balances without incurring extra fees or interest on unpaid balances. However, a fee of \$25 per month will be assessed for any month where no payment is received.

Late fees: Services are provided free of interest on any outstanding balances. However, late fees of \$25 per month, assessed on the first statement on the bi-monthly cycle, will be added if no payment is made each month. There is no minimum payment required. We are simply asking that a payment is made monthly. Please contact me if missed payments are due to pending reimbursements from FSA/HSA accounts in order to waive any penalties.

A Note About Insurance / Managed Care - I do not accept insurance plans nor will most insurance companies reimburse you for these services. This decision is, in part, to protect you from long-term consequences of seeking out mental health services. Any diagnosis provided your insurance and/or managed care company will become a permanent part of your medical records and could have future implications for premiums of life and/or disability policies. However, you may be reimbursed for my services by your Health Savings Account (HSA). Please consult your tax professional to confirm this benefit.

LICENSING & ETHICAL INFORMATION - I am licensed by the state of Illinois to practice Mental Health Counseling (license number: 178.005789). I am also privately insured as a Licensed Professional Counselor. I promise to adhere to the ethical principles of the American Counseling Association. A copy of the ethical guidelines can be viewed at <http://www.counseling.org/resources/aca-code-of-ethics.pdf>. I am also a certified educator (certificate number: 1964084) whose credentials can be checked (using my maiden name, Amy Krichman) online at <https://www.isbe.net/Pages/Educator-Licensure-Information-System.aspx>.

CONFIDENTIALITY / PRIVILEGE / PRIVACY – The American Counseling Association’s Code of Ethics specifically allows for licensed counselors to act in an advocacy role:

“A.7.a. When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients.”

Therefore, all legal and ethical protections that are afforded clients in a mental health relationship are also afforded to clients engaging in educational advocacy services.

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You are the rightful owner of all documents and correspondence related to this agreement. All information obtained as part of this agreement is also confidential and will not be revealed to anyone without your written consent. Confidentiality is also a right of minor children between the ages of 12 and 17. (See Mental Health and Developmental Disabilities Code, 405 ILCS 5/3-301, 405 ILCS 5/3-302, and Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/5.) It is important for you to know that there are some exceptions to confidentiality. If an exception should arise, I will make every effort to inform you, before doing so, of the necessity to break confidentiality.

Exceptions to Confidentiality & Privilege:

- 1) If you threaten harm or death to yourself or another person, I am legally, ethically and morally required to take action to protect the safety of the threatened person. Actions could include: informing the intended victim, arranging for hospitalization for you and/or your child, notifying family or support system, or alerting law enforcement.
- 2) If abuse or neglect of a child, aged person, or disabled person is known or suspected, I am required by Illinois law to report my concerns to the Department of Children and Families.
- 3) If I were to receive a legally binding Court Order for your coaching records or for my deposition or court testimony, I would be required to comply.
- 4) If you or your child are in counseling or are being evaluated by Order of the Court or as condition of continued employment, I may be required to provide the Court or the Employer with reports, documents, or testimony.

Please complete and sign this consent for educational counseling services and the attached consent for collateral contacts. (You will need a separate consent form for each contact but not for multiple personnel at one location.) You will receive a copy of this agreement and can use your canceled checks as receipts for your records.

Very truly yours,

Amy Slutzky

Amy Slutzky, MA, LPC, NCC

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CONSENT FOR EDUCATIONAL ADVOCACY SERVICES

I/We agree to the terms for educational advocacy services detailed in the enclosed letter.

Name of child: _____

Grade/Placement for 20__-20__ school year: _____

Name of school/program for 20__-20__ school year: _____

Address of school/program for 20__-20__ school year:

(Parent/Guardian **printed** name)

(Parent/Guardian **printed** name)

(Parent/Guardian Signature) Date

(Parent/Guardian Signature) Date

If student is 12 years old or older, please complete the additional consent section below:

(Student **printed** name)

(Student signature) Date

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CONSENT FOR RELEASE OF INFORMATION

As parent/guardian of _____ (date of birth: _____),
PLEASE PRINT (student/participant)

I hereby consent to the mutual disclosure and release of all applicable medical, educational and/or therapeutic information between LiveNLearn, LLC and Amy Slutzky, MA, LPC, NCC and

Name of School and/or Facility		Name and title of representative		
_____		_____		
Address	City	State	Zip	
_____	_____	_____	_____	
Phone Number with Area Code		Email Address		
_____		_____		

Professional's relationship to participant: _____

How long has professional known participant? _____

Parent/Guardian: Please sign and return form to LiveNLearn, LLC via USPS or email (amy@livenlearnconsulting.com).

I understand that this information will be used to facilitate medical, educational and/or therapeutic planning for my child.
(Note: These records become a part of the student's temporary and/or permanent records and, as such, are subject to the "Illinois School Student Records Act," Chapter 122, Section 50, Illinois revised statutes.)

This authorization remains valid for one year from date of signature. It is released only to that facility or person named and shall not be further disclosed or utilized for any purpose not specified herein. I understand that I have the right to revoke this authorization (AT ANY TIME) by submitting such request in writing. I also understand that I have the right to inspect and copy the information disclosed. It is further understood that my refusal to consent to the release of the information specified above will prevent disclosure of this information to the person/facility named above.

Parent/Guardian Signature _____ Date _____