Megan Robert
Owner of After the Stork, LLC
Child Sleep Coach | Postpartum Doula | Former Nanny
530-637-8675
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www.afterthestorksleep.com

SLEEP CONSULTATION AGREEMENT FORM

This agreement made and entered into effect on _____, 2020, is by and between Megan Robert and _____ (Client), parents of _____ (Child).

If this agreement form is not signed and returned within 14 days of the effective date, this agreement form is no longer valid. To move forward, Ms. Robert and Client will need to sign a new agreement form.

1. _____ _____ CONSULTATION SERVICES Client hereby employs Ms. Robert to perform the following services in accordance with the terms and conditions set forth in this agreement. The documents and information provided with these services are limited to Child.

2. _____ _____ TERMS OF AGREEMENT Ms. Robert will provide a consultation to Client regarding the implementation of healthy sleep habits for Child and include the following services for the consulting package purchased:

- ❖ Sixty minute video or phone consultation via Zoom. Ms. Robert will provide conference call information once Client has notified Ms. Robert of a date and time for the consultation within Ms. Robert's availability provided via email as well as preference for phone or video consultation.
  - ❏ Phone Consultation
  - ❏ Video Consultation
- ❖ Customized Sleep Plan (SP) that covers how to address the individual sleep needs of Child.

Following the initial conversation, Client will receive a SP via email within 24 business hours, unless another time is agreed upon between Ms. Robert and Client. Client will have 24-hours to review the SP and the opportunity to ask questions or clarify any concerns with Ms. Robert via phone or email.

IN-HOME UPGRADE

- ❏ IN-HOME Upgrade to an in-home consultation. This allows for a deeper dive and evaluation of the sleep environment along with a more personal touch. Hugs available with a loud whisper to say, "You're doing a great job!"

  This consultation is to sit down with Client to discuss sleep without the child(ren). It is not required but highly suggested for Client to have a child care provider to watch over the child(ren) so that Client can focus completely on our discussion.

  STREET: _____

  APT: _____

  CITY _____ , VA ZIPCODE _____

3. _____ _____ SUPPORT OPTIONS As a previous client with services pertaining to a previous child, support while implementing the SP is optional for Client.

- ❏ NO SUPPORT Consultation only.
- ❏ ONE WEEK OF SUPPORT Seven days of daily text support within the following parameters: Sunday-Saturday 9 am - 5 pm EST with a response within three hours on weekdays and when available on weekends. Ms. Robert will provide support as outlined below to end seven days from the date of implementation of SP.

If support is chosen, Client agrees to start the implementation of the SP within one week of receiving SP and to commit to the SP as written for the time period chosen in order to establish healthy sleep habits of Client's child with the guidance of Ms. Robert, unless otherwise agreed upon between Ms.

Robert and Client. Ms. Robert reserves the right to terminate this agreement if Client breaches any of the terms of this agreement. All levels for support other than "No Support" include the following:

- ❖ Analysis of data logged in real time. Client is to use the app Baby Connect so that Ms. Robert can provide support. If Client was not gifted Baby Connect from working with Ms. Robert previously, Daily Connect will be used with Ms. Robert providing Client a profile for Child.
- ❖ Daily text support to help Client implement the plan correctly and troubleshoot when needed for the duration of time chosen above.
- ❖ 15-Minute phone call at the end of the time chosen to go over what to expect in the future and for Ms. Robert to answer any extra questions from Client regarding sleep.

4. _____ _____ PAYMENT Total payment of _____ will be made to Ms. Robert for the work that will be provided in accordance with this agreement at least 48-hours prior to the consultation unless otherwise discussed. Ms. Robert will or has provided an invoice outlining all services to be rendered and collect payment in full before the initial consultation with Client. Client will have the option to seek additional support from Ms. Robert if requested at a rate dependent upon the level of support being sought. Payments are non-refundable.

CONSULTATION PAYMENT

- ❑ _____ _____ CONSULTATION WITH ONE WEEK OF SUPPORT Payment of _____ will be made to Ms. Robert for the consultation.
- ❑ _____ _____ CONSULTATION WITH TWO WEEKS OF SUPPORT Payment of _____ will be made to Ms. Robert for the consultation.

IN-HOME UPGRADE PAYMENT

- ❑ _____ _____ IN-HOME In-home consultation. Additional payment of _____ will be made to Ms. Robert prior to the start date.

5. _____ _____ REQUIREMENTS PRIOR TO CONSULTATION Client understands that the following must be done at least 48-hours prior to the consultation time unless otherwise discussed.

- ❖ Sign and return this agreement form.
- ❖ Fill out the After the Stork Intake Form.
- ❖ Make the appropriate payment.

6. PARENT COMMITMENT Client understands that their commitment to this process is absolutely necessary in order to see the results they are hoping for in regards to their child's sleep.

a. _____ _____Client agrees to follow current recommendations from the American Academy of Pediatrics on safe sleep practices.

b. _____ _____ Client agrees to download the app Daily Connect and to log sleep, feedings, notes, etc. in real time. Ms. Robert will provide a profile for Child that Client is to use in order to track progress.

c. _____ _____ Client understands that Ms. Robert does not guarantee success as several factors contribute to whether or not sleep training will work for Client's child.

d. _____ _____ Client understands that Ms. Robert encourages and enjoys updates from them, and that it is their responsibility to correspond with Ms. Robert.

e. _____ _____ Client agrees to bring up any concerns, doubts, or confusion in regard to the Sleep Plan developed with Ms. Robert and as soon as possible so Client and Ms. Robert may address them constructively in order to work together to achieve Client's desired goals.

f. _____ _____ Client understands that Ms. Robert is generally available to answer questions on weekdays during business hours and as needed on weekends, and that correspondence received at night, holidays, and weekends will generally be answered the next business day. However, if Client is truly distressed, worried, or concerned, Client will call Ms. Robert so that she can assist and direct them as promptly as possible.

7. _____ _____ CONSULTING THE CLIENT'S HEALTH CARE PROVIDER It is Client's responsibility to consult with with Client's pediatrician, family physician, and/or any other health care providers necessary ("health care provider") to rule out any underlying medical conditions that may be causing sleep problems (including, but not limited to sleep apnea, ear infection, allergies, asthma), as well as ensure that the health care provider has advised that Client's child is healthy, gaining weight appropriately, is thriving, and that it is appropriate to implement the Sleep Plan that may include

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ceasing night feedings. Client agrees to notify Ms. Robert of any medical changes during the sleep training process.

8. _____ _____ LIABILITY AND DISCLAIMER The information provided by Ms. Robert is neither intended nor is implied to be a substitute for professional medical advice. This consultation is intended as an educational service. Client is advised to always seek the advice of a physician or other qualified healthcare provider with any questions you may have regarding a medical condition or the health and welfare of Client's baby, toddler, or child. Ms. Robert will use reasonable efforts to include up-to-date and accurate information in consults, but makes no representations, warranties, or assurances as to the accuracy, currency, or completeness of the information provided. Ms. Robert shall not be liable for any damages or injury resulting from Client's access to, or inability to access the information discussed, or from Client's reliance on any information provided by Ms. Robert. This consultation may provide references to other materials and resources but Ms. Robert will have no responsibility for the content of such other references and shall not be liable for any damages or injury arising from that content. Any references provided by Ms. Robert are provided as merely a convenience to the user.

9. _____ _____ CONFIDENTIAL INFORMATION Ms. Robert agrees that any information received by her during any furtherance of her obligations in accordance with this agreement which concerns the personal, financial, or other affairs of Client will be treated by Ms. Robert in full confidence and will not be revealed to any other persons or organizations without the written consent from Client. Client agrees to keep the sleep plan provided by Ms. Robert for Client's personal use and will not share the content of the sleep plan with outside parties without written consent from Ms. Robert, with the exception of Client's health care provider and any fellow caregivers of Client's child unless the caregivers are staff of a daycare facility. If Client's child attends daycare and information will be provided to the daycare staff, Ms. Robert will write up a separate document that includes only the information that they need. Prior to doing so, Client must inform Ms. Robert of this.

10. SIGNATURE Please initial all of the above and sign below. Both Client (all parents) and Ms. Robert agree to the above agreement.

Client/Parent/Guardian: _____

Date: _____

Client/Parent/Guardian: _____

Date: _____

Child Sleep Coach: _____

Date: _____

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