Poehailos, Dupont & Associates
887B Rio East Court
Charlottesville, VA 22911
434-220-4686

Contract for Psychological Testing for Children and Adolescents

Patient: ____________________________ Date: ______________

Responsible Parent: ____

Referral Questions: ____

Tests/Procedures Requested and Fees:

Cognitive/Intelligence Scales

____ Wechsler Intelligence Scale for Children – Fifth Edition (2 units @ $200/unit)

____ Woodcock-Johnson IV Tests of Cognitive Abilities (2 units @ $200/unit)

____ Other ____ (___ unit(s) @ $200.00/unit)

Academic Achievement Tests

____ *Woodcock-Johnson IV Tests of Achievement (2 units @ $200/unit)

____ *Other: ____ (___ unit(s) @ $200.00/unit)

Behavioral Rating Scales

____ Behavior Assessment System for Children: ____ forms (1 unit @ $200.00)

____ Connors: ____ forms (1 unit @ $200.00)

____ Other: ____________________________________: _____ forms (1 unit @ $200.00)

Measures of Personality/Emotional Functioning

____ Minnesota Multiphasic Personality Inventory-Adolescent (1 unit @ $200.00)

____ Roberts Apperception Scale for Children (1 unit @ $200.00)

____ Rorschach Inkblot Method (2 units @ $200.00/unit)

____ Other: ____(_____ unit(s) @ $200.00/unit)

Report Writing

____ *____ Units @ $200.00/unit = ______________________

I understand that testing/evaluation measures indicated by an * are not reimbursed by my health insurance and I agree to pay those fees. Other fees may not be reimbursed by insurance and/or managed care companies. I agree that fees will be remitted to Poehailos, Dupont & Associates (PDA) on the day of testing.

_____________________________________ ___________________

Signature of responsible parent Date

Updated 6/1/2015

Poehailos, Dupont, & Associates, PLC

Child/Adolescent Assessment Contract for Payment Explanation

I am agreeing to an assessment for my child, ______________________ (DOB __________), with ____ of Poehailos, Dupont, & Associates, PLC.

I understand that should I call to cancel my child's appointment with less than 24 hours notice, or no-show for my child's appointment, I will be charged in full for the session.

Assessment is billed by the hour and the fee is $200 per hour. A missed appointment is not billable to insurance and my credit card on file (see Contract for Payment section on page 2 of Patient Registration) will be processed for the full amount. For example, if my child misses an appointment scheduled from 9 am to 11 am, I will be charged $400 (2 hours @ $200 per hour).

Patient Name____

Parent Signature & Date____

Witness Signature & Date ____