

Poehailos, Dupont & Associates, PLC

Contract for Assessment of Autism Spectrum Disorder in Adults

Patient: _____

Date: _____

Responsible Parent: _____

Referral Question: _____

Tests/Procedures Requested and Fees:

Autism Spectrum Evaluation

____ Autism Diagnostic Observation Schedule (3 units @ \$225/unit)

Cognitive/Intelligence Scales

____ Wechsler Adult Intelligence Scale, Fourth Edition (2 units @ \$225/unit)

____ Woodcock-Johnson IV Tests of Cognitive Abilities (2 units @ \$225/unit)

Academic Achievement Tests

____ *Woodcock-Johnson IV Tests of Achievement (2 units @ \$225/unit)

Behavioral Rating Scales

____ Social Communication Questionnaire: ____ forms (1 unit @ \$225/unit)

____ Social Responsiveness Scale, Second Edition: ____ forms (1 unit @ \$225/unit)

____ Vineland Adaptive Behavior Scales, Third Edition (1 unit @ \$225/unit)

____ Minnesota Multiphasic Personality Inventory, Second Edition (1 unit @ 225/unit)

____ Millon Clinical Multiaxial Inventory, Fourth Edition (1 unit @ 225/unit)

Other:

____ Developmental History and Parent Interviewing (2 units @ \$225/unit)

Report Writing

____ * ____ units @ \$225/unit = _____

I understand the testing/evaluation procedures 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 patient

Date