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

Contract for Assessment of Autism Spectrum Disorder in Children and Adolescents

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 Intelligence Scale for Children – Fifth Edition (2 units @ $225/unit)

____ Wechsler Preschool and Primary Scale of Intelligence – Fourth Edition (2 units @ $225/unit)

____ Other: _____ (___ unit(s) @ $225/unit)

Academic Achievement Tests

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

____ * Other: _____ (___ unit(s) @ $225/unit)

Behavioral Rating Scales

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

____ Achenbach System of Empirically Based Assessment: ___ forms (1 unit @ $225/unit)

____ Vineland Adaptive Behavior Scales, Third 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