Autism Behavioral Consulting LLC

PURCHASE OF SERVICE CONTRACT

THIS AGREEMENT, to be effective the ____day of _____, 20____, between AUTISM BEHAVIORAL CONSULTING, LLC hereinafter called PROVIDER and _____ hereinafter called CLIENT.

SERVICES

Services set forth herein are provided on a non-exclusive basis and unless otherwise stated, do not obligate the PROVIDER to additional services upon completion.

- Pre Clinic Consultation and Parent Interview - initial consultation with CLIENT, serves to obtain educational, medical and developmental information while observing the CLIENT in his or her natural environment.
- Clinical Evaluation- through the use of standardized assessments, informal assessments and autism specific evaluation instruments the PROVIDER will evaluate intellectual functioning, adaptive and maladaptive behavior, communication and academic functioning. Upon completion of the evaluation, provider will provide an evaluation report to include clinical results and recommendations.

FEES

- Pre Clinic Consultation and Parent Interview. The CLIENT shall pay a per hourly fee of $100.00. Upon completion, the PROVIDER will invoice CLIENT for such fee. The CLIENT shall receive a written report. This report may be within the complete evaluation report.
- Clinical Evaluation - The CLIENT shall pay a flat rate fee of $1,500.00 for an evaluation at the PROVIDER'S office in Sioux Falls. The evaluators include a Speech Language Pathologist, a Psychologist, and an Educator.
- In addition, travel related expenses, if incurred, shall be invoiced at the rate set forth herein. Per diem shall be billed for each day of service (including travel) for each PROVIDER at the rate of $50.00 per day, additionally, mileage shall be billed at a per mile rate of 62.5 cents or current Federal rate.
- Report writing for the pre clinic report is billed at $50.00/hour. There is not a report writing fee for the evaluation report.

If there is a cancellation, without a 48 hour notice to the provider, there will be a cancellation fee of $500 charged.

If the evaluation needs to be conducted at the student's school location there is a different rate structure. Please contact ABC for that information.

PAYMENT

We do not bill private insurance including Medicaid. CLIENT assumes full financial responsibility for the evaluation. Balances left unpaid for over 60 days will incur a 5% finance charge. Unpaid balances after 90 days will incur a 10% charge on any unpaid balance. Payments for services provided to an organization (agency, school or school district) shall be arranged prior to services being rendered. Acceptable forms of payment include check and money order. By signing below the CLIENT acknowledges that he or she has read and understands the agreement above. The CLIENT understands that he or she is responsible for timely payment of all fees and in the event of a third party payer, is financially responsible for payment should the third party fail to do so.

CLIENT: _____

PROVIDER: AUTISM BEHAVIORAL CONSULTING, LLC, Brittany Schmidt, Owner

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