ABCD, INC.

ASSOCIATES IN BEHAVIOR AND CHILD DEVELOPMENT
155 NE 100TH STREET, SUITE 306
SEATTLE, WA 98125
PHONE: 206-569-3361 FAX: 206-361-1598

INITIAL CONTACT FORM FOR PSYCHOEDUCATIONAL EVALUATIONS

Child's Name: ______________________ Birth date: ______________

Child's School: ______________________ Grade in school: __________

Today's Date: ____________ Home Phone: ____________________

Name of person completing form: ______________________________

Relation to child ______________________________________

Is this your biological child?________ Adopted?______ Your stepchild? _____

Who referred you to ABCD or how did you learn about our services?

____

Who is your child's physician? ________________________________

Family Contact Information

Parent #1 name ________________________ Phone/Cell: __________

Home Address: ____

Parent #2 name ________________________ Phone/Cell: __________

Address: (if different from Parent #1) _________________________

Email address:____

Marital Status: Parent #1 ______________ Parent#2 ______________

Please briefly describe the concerns or problems that led you to seek a psychoeducational evaluation for your child:

Please list any prior testing that has been done by school staff or other specialists (for example, occupational therapy, speech therapy, special education evaluation, etc.)

ABCD, INC. / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

PRELIMINARY FINANCIAL AGREEMENT

SERVICE AND FEES:

Service	Fee
Initial Session with Parents	$320
First Test Session	$475
Second Test Session	$475
Third Test Session	$475
Session to Discuss Results and Recommendations	$285
Total Services:	$2030

**Please initial each line. Thank you.*

I, the parent/legal guardian/client, understand that:

1. Dr. Higgins is not a contracted (preferred) provider with my insurance carrier and is considered out of network. _______
2. I am responsible for all of the charges for services provided to my child by Dr. Higgins. I understand that this office will not be able to divide financial responsibility between parties. _______
3. Many insurance companies do not cover the services provided by Dr. Higgins. _______
4. The submission of insurance claims is my sole responsibility. ABCD, Inc. will provide me with an invoice to submit to my insurance company. _______
5. Payment in full is due at the beginning of every appointment. We gladly accept cash, check, VISA, and MasterCard. _______

I, the parent/legal guardian/client have been notified that:

1. It is my responsibility to contact my insurance carrier to determine whether the services by Dr. Higgins meet the criteria for reimbursement. I understand that some insurance plans exclude evaluations of learning and/or attention disorders (AD/HD). _______
2. It is my responsibility to obtain any required pre-authorizations and/or referrals required by my insurance provider prior to my first appointment. _______

Your signature below verifies that you have read this document and agree to abide by our office policy and will accept the conditions.

____________________	____________________	____________
Patient Name (child)	Personal Representative (parent)	Date