ABCD, INC. / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

PRELIMINARY FINANCIAL AGREEMENT

SERVICE AND FEES:	
Initial Session with Parents	$300
First Test Session	$450
Second Test Session	$450
Third Test Session	$450
Session to Discuss Results and Recommendations	$270
Total Services:	$1920

**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