



Staff Use only (initials/date rec'd):

Clinical Services Request

Rates effective 7/1/26

Client's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Phone _____ Email: _____

SELECT SERVICE(S)*	RATE
<input type="checkbox"/> 1:1 Applied Behavior Analysis (ABA) Therapy with Behavior Technician BCBA/BCaBA Treatment Planning/Client Treatment/ Family Guidance	\$113/hour \$195/hour
<input type="checkbox"/> Diagnostic Evaluation	\$200/hour
<input type="checkbox"/> Individual Counseling/Psychotherapy (30/45/60 minutes)	\$125/\$187/\$217
<input type="checkbox"/> Family Counseling/Psychotherapy	\$187/hour
<input type="checkbox"/> Couples counseling (specializing in couples with neurodivergent partner(s))	\$187/hour
<input type="checkbox"/> Offsite Consultation with BCBA/BCaBA (travel charges may apply)	\$195/hour

*May be covered through private health insurance and/or Medicaid and subject to co-pays or co-insurance

SIGNATURE OF PARENT/GUARDIAN

DATE

*This is a request form only and not a guarantee of services.
This form is not a replacement for any insurance company or other funders' requirements.*

Return completed form to: clientrelations@abcofnc.org