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

Clinical Services Request

Rates effective 7/1/25

Client's Name: _____ DOB: _____

Parent/Guardian Name(s): _____ Phone _____

_____ Email: _____

SELECT SERVICE(S)*	RATE
☐ 1:1 Applied Behavior Analysis (ABA) Therapy with Behavior Technician BCBA/BCaBA Treatment Planning/Client Treatment/ Family Guidance	$110/hour
	$189/hour
☐ Diagnostic Evaluation	$194/hour
☐ Individual Counseling/Psychotherapy (30/45/60 minutes)	$121/$182/$211
☐ Family Counseling/Psychotherapy	$182/hour
☐ Couples counseling (specializing in couples with neurodivergent partner(s))	$182/hour
☐ Offsite Consultation with BCBA/BCaBA (travel charges may apply)	$189/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