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

Clinical Services Request

Rates effective 7/1/26

Client Name: _____ DOB: _____

Parent/ Guardian Name: _____

Phone: _____ Email: _____

SELECT SERVICE(S)*	RATE
☐ 1:1 Applied Behavior Analysis (ABA) Therapy with Behavior Technician BCBA/BCaBA Treatment Planning/Client Treatment/ Family Guidance	$113/hour $195/hour
☐ Diagnostic Evaluation	$200/hour
☐ Individual Counseling/Psychotherapy (30/45/60 minutes)	$125/$187/hour
☐ Family Counseling/Psychotherapy	$217/$187/hour
☐ Couples counseling (specializing in couples with neurodivergent partner(s))	$187/hour
☐ 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