BCS, INC.
Behavior Care Specialists, Inc.

PURCHASE OF SERVICE CONTRACT

THIS AGREEMENT, to be effective the ____day of _____, 20____, between BEHAVIOR CARE SPECIALISTS, INC. and AUTISM BEHAVIORAL CONSULTING, LLC hereinafter called PROVIDER _____ hereinafter called CLIENT.

SERVICES

Services set forth herein are provided on a non-exclusive basis and unless otherwise stated, do not obligate the PROVIDER to additional services upon completion.

- Pre Clinic Consultation - initial consultation with CLIENT, serves to obtain medical and developmental information while observing the CLIENT in his or her natural environment.
- Clinical Evaluation- through the use of standardized assessments and autism specific evaluation instruments the PROVIDER will evaluate intellectual functioning, adaptive and maladaptive behavior, communication and academic functioning. Upon completion of the evaluation, provider will provide an evaluation report to include clinical results and recommendations for intervention programming.

The PROVIDER agrees to not assign any provision of this contract to a subcontractor and honor the fees related to the services provided above.

FEES

- Pre Clinic Consultation - The CLIENT shall pay a per hour fee of $100.00. Upon completion, the PROVIDER will invoice CLIENT for such fee. The CLIENT shall receive a written report. This report may be within the complete evaluation report.
- Clinical Evaluation - The CLIENT shall pay a flat rate fee of $1,800.00 for an evaluation at the PROVIDER'S office in Sioux Falls or Rapid City. The evaluators include a Speech Language Pathologist, a Psychologist, and an Educator.
- In addition, travel related expenses shall be invoiced at the rate set forth herein. Per diem shall be billed for each day of service (including travel) for each PROVIDER at the rate of $45.00 per day, additionally, mileage shall be billed at a per mile rate of 57.5 cents or current Federal rate. As appointment schedule and/or location of evaluation deems necessary, a hotel fee shall be invoiced upon completion of service.
- Report writing for the pre clinic report is billed at $40.00/hour. There is not a report writing fee for the evaluation report.

PAYMENT

If private insurance is to be used for the psychology evaluation ($600) it is recommended that the CLIENT contact the insurance company prior to any service to fully understand the services covered. The Communication and Education portions of the evaluations will not be billed to insurance. Medicaid will not billed for any part of the evaluation.

In the event that the CLIENT'S insurance plan determines that the Psychology Evaluation ($600) to be "non-covered," the PROVIDER will bill the CLIENT whereas payment is due upon receipt of statement.

SIOUX FALLS
1105 W. Russell St.
Sioux Falls, SD 57106
Phone: 605-351-1002
FAX: 605-271-3956

RAPID CITY
3820 Jackson Blvd.
Rapid City, SD 57702
Phone: 605-351-1002
FAX: 605-XXX-XXXX

www.abc-autism.com www.behaviorcarespecialists.com

CLIENT assumes full financial responsibility for remaining balances left unpaid by the insurance company.

Balances left unpaid for over 60 days will incur a 1.5% finance charge whereas balances unpaid after 90 days will be sent to collection.

Payments for services provided to an organization (agency, school or school district) shall be arranged prior to services being rendered. Acceptable forms of payment include check and money order.

By signing below the CLIENT acknowledges that he or she has read and understands the agreement above. The CLIENT understands that he or she is responsible for timely payment of all fees and in the event of a third party payer, is financially responsible for payment should the third party fail to do so.

CLIENT_____

PROVIDER_____

BEHAVIOR CARE SPECIALISTS, INC., Alison Hulshof, President
AUTISM BEHAVIORAL CONSULTING, LLC, Brittany Schmidt, Owner

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INSURANCE & BILLING INFORMATION

Provide this information IF you will be contacting your insurance company about the Psychology portion of this evaluation.

INSURANCE INFORMATION

Primary Insurance _____ Policy Number_____

Policy Holder _____ _____ _____
Last First MI

Date of Birth _____/_____/_____ SSN# _____-_____-_____

RELATIONSHIP TO PATIENT (IF NOT PARENT, PLEASE PROVIDE LEGAL DOCUMENTATION OF GUARDIANSHIP)

PARENT GUARDIAN FOSTER PARENTOTHER_____

EMPLOYER _____

SECONDARY INSURANCE _____ POLICY NUMBER _____

POLICY HOLDER _____ _____ _____
Last First MI

DATE OF BIRTH_____/_____/_____ SSN# _____-_____-_____

RELATIONSHIP TO PATIENT (IF NOT PARENT, PLEASE PROVIDE LEAGAL DOCUMENTATION OF GUARDIANSHIP)

EMPLOYER _____

ORGANIZATION BILLING INFORMATION

TYPE OF ORGANIZATION SCHOOL SCHOOL DISTRICT AGENCY

BILLING CONTACT_____

ORANIZATION_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____-_____ FAX (_____) _____-_____

EMAIL ADDRESS _____

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