

[TO BE COMPLETED BY CLINICIAN]

Poehailos, Dupont & Associates  
887B Rio East Court  
Charlottesville, VA 22911  
434-220-4686

***Contract for Psychological Testing for Adults***

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Referral Questions: \_\_\_\_\_

\_\_\_\_\_

**Tests/Procedures Requested and Fees:**

*Cognitive/Intelligence Scales*

\_\_\_\_\_ Wechsler Adult Intelligence Scale– Fourth Edition (2 units @ \$200/unit)

\_\_\_\_\_ Woodcock-Johnson IV Tests of Cognitive Abilities (2 units @ \$200/unit)

\_\_\_\_\_ Other \_\_\_\_\_ ( \_\_\_\_\_ unit(s) @ \$200.00/unit)

*Academic Achievement Tests*

\_\_\_\_\_ \*Woodcock-Johnson IV Tests of Achievement (2 units @ \$200/unit)

\_\_\_\_\_ \*Other: \_\_\_\_\_ ( \_\_\_\_\_ unit(s) @ \$200.00/unit)

*Behavioral Rating Scales*

\_\_\_\_\_ Barkley Adult ADHD Rating Scale—IV (BAARS-IV): \_\_\_\_\_ forms (1 unit @ \$200.00)

\_\_\_\_\_ Behavior Rating Inventory of Executive Function (BRIEF): \_\_\_\_\_ forms (1 unit @ \$200.00)

\_\_\_\_\_ Other: \_\_\_\_\_: \_\_\_\_\_ forms (1 unit @ \$200.00)

*Measures of Personality/Emotional Functioning*

\_\_\_\_\_ Minnesota Multiphasic Personality Inventory (1 unit @ \$200.00)

\_\_\_\_\_ Thematic Apperception Test (1 unit @ \$200.00)

\_\_\_\_\_ Rorschach Inkblot Method (2 units @ \$200.00/unit)

\_\_\_\_\_ Other: \_\_\_\_\_ ( \_\_\_\_\_ unit(s) @ \$200.00/unit)

*Report Writing*

\_\_\_\_\_ \* \_\_\_\_\_ Units @ \$200.00/unit = \_\_\_\_\_

I understand that testing/evaluation measures indicated by an \* are not reimbursed by my health insurance and I agree to pay those fees. Other fees may not be reimbursed by insurance and/or managed care companies. I agree that fees will be remitted to Poehailos, Dupont & Associates (PDA) on the day of testing.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

**Poehailos, Dupont, & Associates, PLC**

**Adult Assessment Contract for Payment Explanation**

I, \_\_\_\_\_, agree to participate in an assessment with \_\_\_\_\_ of Poehailos, Dupont, & Associates, PLC.

I understand that should I call to cancel my appointment with less than 24 hours notice, or no-show for my appointment, I will be charged in full for the session.

Assessment is billed by the hour and the fee is \$200 per hour. A missed appointment is not billable to insurance and my credit card on file (see Contract for Payment section on page 2 of Patient Registration) will be processed for the full amount. For example, if I miss an appointment scheduled from 9 am to 11 am, I will be charged \$400 (2 hours @ \$200 per hour).

Patient Name \_\_\_\_\_

Parent Signature & Date \_\_\_\_\_

Witness Signature & Date \_\_\_\_\_