Little Johnny, LLC

603 East Main Street

Lexington, SC 29072

Phone (803) 520-8365

Email: admin@littlejohnny.org

[www.littlejohnny.org](http://www.littlejohnny.org)

Please check the assessment you are requesting.

\_\_\_ Full Psychoeducational Evaluation (Ages 5+) - $900 \_\_\_ Autism Evaluation - $1500

\_\_\_ Learning Disability Evaluation (Ages 5+) - $700 \_\_\_ ADOS-2 - $950

\_\_\_ Developmental Skills Evaluation (Ages 3-5) - $775 \_\_\_ Speech Language Evaluation - $350

\_\_\_ ADHD Testing (Ages 3+) - $600 \_\_\_ Early Grade Placement Evaluation - $1150

Financial Information: A 50% nonrefundable deposit is required for testing to reserve an appointment. Full payment is due before the evaluation review. The full fee is charged for missed or cancelled sessions without 48 hours advanced notice. There is a $35 fee for returned checks in addition to a late fee of 25%.

Insurance Information: Little Johnny, LLC does not accept insurance, and will not call, write or fax insurance companies. Rather, Little Johnny provides information to the client, such as an itemized invoice, that the client may forward to an insurance company. The client must request this information directly as Little Johnny, LLC will not respond to requests by insurance companies in order to maintain your confidentiality.

Insurance companies set the rules for reimbursement, and Little Johnny cannot provide any assurance that testing services will be covered by insurance. Little Johnny, LLC will not include, delete or alter any information on an invoice in order to qualify for or increase reimbursement. Most insurance companies do not cover psychological testing, and the few that do will typically only reimburse a portion of the costs and may require pre-authorization and/or a referral from a primary care physician. Insurance companies will also only reimburse if they deem the services are medically necessary. This requirement generally excludes any reimbursement for educational services, school meetings, or legal proceedings.

Refunds: We do not offer refunds for any reason including if you are unhappy with any component of the evaluation process (testing, report, or recommendations) or if your insurance company refuses reimbursement of our services.

By signing below, you acknowledge you have read this form and agree to abide the terms. If you have any questions or need clarification, please contact us immediately.

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Parent/Guardian Signature Date

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Printed Name

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Printed Name of Client to be tested Client Date of Birth