

# Precision Behavior Solutions LLC

## ABA Service Agreement

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

### Services Provided:

- ABA assessment and treatment planning
- Direct ABA therapy
- Parent training and caregiver coaching
- School / community collaboration

### Scheduling & Attendance:

Families are expected to attend scheduled sessions consistently. A minimum of 24 hours notice is requested for cancellations. Repeated no-shows or excessive cancellations may result in schedule modification or discharge review.

### Fees & Payment:

Private pay rates and/or insurance responsibility including copays, deductibles, coinsurance, and denied claims remain the responsibility of the parent/guardian.

### Consent:

I understand the nature of ABA services and agree to participate in recommended treatment, parent training, and communication with the clinical team.

### Termination of Services:

Services may be discontinued due to goals met, repeated absences, safety concerns, or non-payment.

Parent / Guardian Signature: \_\_\_\_\_

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