Sensory Pathways 4 Kids

Pediatric Occupational and Physical Therapy

Kari S. Hall MA, OTR

Medicaid Financial Policy effective 01.01.2023

PAYMENT

A **CREDIT CARD** on file is **REQUIRED** for all non-covered Medicaid services and supplies as described below as well as any CHP+ copays if applicable. **These fees are charged either upon receipt of supplies or on or after the 20th of each month and a statement/receipt will be email thereafter.**

_____ _____ _____

Credit card number expiration date 3 digit code on back

Email_____

FEES – Not Covered by Medicaid

Vest, weight, vest deposit	65.00 - 135.00
Therapy Brushes	4.00 – 8.00 ea
Books, pencils, etc	Varies
Consultation – Off-Site, School, Home, Gym	40.00 ea 15 min
Trip charge - for any offsite consults	10.00 per trip
Consultation - Office, Phone, Teacher, Parent	30.00 ea 15 min

SUPPLIES and School Visits

_____ initial

Medicaid states that any non-covered supply can be billed to the Medicaid client. Supplies must be paid in full when they are received. Non-covered supplies may include; brushes, weights, weighted vests/belts/blankets and School Visits/Observations and Consultations.

CONSULTATIONS

_____ initial

OT and PT consultations are not covered by Medicaid and are the responsibility of the client. This includes, but not limited to, phone or office consultations between our office and parents, grandparents, teachers and/or other healthcare professionals.

NO SHOW - LATE CANCELS – Missed Appointments

_____ initial

Failure to cancel an appointment or repeated no shows may result in patient discharge from our office.

_____ initial

All appointments must be cancelled **prior to 6:00 a.m.** the day of your child's appointment.

_____ initial

All appointments should be cancelled via our 24 hour voice message line **(303) 756-0280.**

MEDICAID HMO Plans

_____ initial

We do not participate with DENVER HEALTH or KAISER Medicaid. If you switch to one of these plans, any future appointments will be immediately cancelled.

I have read and understand the above Financial Policy:

_____ _____ _____ _____

Print Child's name Print your name Parent/Guardian Signature Date