Pediatric
POSSIBILITIES, P.A.
"Making it Possible"

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Medicaid Financial and Insurance Policy

Pediatric Possibilities, P.A. is committed to providing you with the best possible care and we are pleased to discuss our professional fees and policies with you at any time. Your clear understanding of our Medicaid Financial and Insurance Policy is important for our professional relationship between provider and client. Please contact the office if you have questions about fees, insurance, or your financial responsibility. **Initial** to consent to the following:

- _____ **PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.** Medicaid policies often cover the full cost of Occupational Therapy services; however, some fees may apply based on your Medicaid plan. The adult accompanying a minor at the time of service is responsible for any payment required based on your Medicaid Plan. For unaccompanied minors, the parents or guardians are responsible for full payment. We accept cash, check, health savings accounts, flexible spending accounts, and all major credit cards.

- _____ Pediatric Possibilities, P.A. reserves the right to change/cancel your regular scheduled appointments due to inconsistent attendance, as inconsistent attendance is considered a "Barrier to Progress" per Medicaid Policy. Three (3) or more consecutive missed appointments may result in either forfeiture of your recurring scheduled appointment time or termination of service. (refer to Attendance Policy for more information)

- _____ Pediatric Possibilities, P.A. is an in-network provider for North Carolina Medicaid. It is the client's responsibility to notify Pediatric Possibilities, P.A. of any changes to your Medicaid coverage, including loss of Medicaid eligibility, lapse in Medicaid eligibility, and/or change in Medicaid plan. **You will be responsible for payment of denied services if you fail to notify Pediatric Possibilities, P.A. with changes in your Medicaid policy prior to a rendered service(s).** Pediatric Possibilities, P.A. requires a copy of your Medicaid card along with any other health insurance information prior to rendering services.

- _____ Medicaid is a payor of last resort. It is your responsibility to notify Pediatric Possibilities, P.A. if you have any additional insurance plans (i.e. commercial, state, or federal plans). You will be responsible for payment of denied services if you fail to notify Pediatric Possibilities, P.A. with changes in your Medicaid and/or other insurance policies prior to a rendered service(s).

- _____ Clients can be charged for other services performed and/or provided by Pediatric Possibilities, PA. These services will be billed as Consultation Services at a rate of $160 per hour. These services include but are not limited to, preparation of written reports, phone calls, emails, collaboration with other professionals, etc. These charges will be billed directly to the client and will not be billed to Medicaid insurance as these services are not covered by Medicaid insurance.

- _____ Pediatric Possibilities, P.A. is the Medicaid Provider and we must report any additional reimbursements to Medicaid. If a commercial, state, or federal insurance plan reimburses a client for therapy services, Pediatric Possibilities, P.A. must collect those checks from the client. **Please do not deposit any checks you receive and bring them in to Pediatric Possibilities, P.A.**

- _____ I authorize Pediatric Possibilities, P.A. to release medical information required to process my insurance claims.

Services and Fees – These fees will be covered by Medicaid and will only be the responsibility of the client if the client no longer qualifies for Medicaid. (This serves to comply with all Good Faith Estimate requirements) Any additional fees not covered by Medicaid will be discussed and agreed upon prior to implementation. Initial to consent to the following:

_____ Evaluation Fee: $425; This includes a full evaluation and written report

_____ Treatment Fee: $160/hour

The following services are **NOT** covered by Medicaid or other insurances and will be the responsibility of the client:

_____ Caregiver Consultation Fee: $160/hour **Consultation fees are not billable to Medicaid**

_____ Consultation Fee: $160/hour (*This fee is incurred for meetings with schools, teachers, therapists, etc.*) **Consultation fees are not billable to Medicaid**.

_____ Missed Appointment or Late Cancellation Penalty: Potential forfeiture of therapy services.

By signing below, I acknowledge receiving thIs policy and fee schedule prior to services rendered and understand that I am responsible to pay for services rendered and agree to this policy.

Client Signature (Parent or Guardian if Client is a minor)	Date
Print Parent or Guardian Name	Client's Name