

FINANCIAL POLICY effective 01.01.2023

SP4Kids provides professional Physical and Occupational therapy services. Fees and costs are based on services provided. We encourage you to discuss questions on fees for any service with our billing department and/or your insurance company. Your clear understanding of our financial agreement is important to our professional relationship.

<u>Evaluation & Feedback(FB)</u>	\$560.00 - 750.00	<u>60 min session*</u>	\$140.00 (53 min treatment, 7 min admin)
<u>Yearly administration fee</u>	\$ 10.00 (or new insurance)	<u>Monthly re-eval</u>	\$ 60.00

FEES NOT billed to Insurance – Non-Covered Services

Consults in Office, by Phone or Email, parent/teachers, etc.	\$30.00 each 15 min.
Consults out of office/School Observation	\$40.00 each 15 min. plus \$10 trip charge
Failure to pay upon receipt and Returned checks	\$35.00 each occurrence
<u>LATE CANCEL</u>	\$45.00 charged if appt. is not canceled prior to 6:00a.m. on the day of your appointment
<u>NO SHOW</u>	\$75.00 charged if you fail to show for the scheduled appointment for any reason

Leave all messages on your therapists' 24 hour voicemail line (303) 756-0280

In consideration of treatment by Sensory Pathways 4 Kids, I the undersigned(s), jointly and severally understand and agree:

- 1) That I am responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by Sensory Pathways 4 Kids and staff to me, my family, or other individuals I have authorized. Besides myself, I authorize discussion of the financial account with the following individual(s) _____
- 2) That I recognize my insurance is a contract between the member and insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage, insurance benefit quote, including services denied by my insurance company, for any reason including not medically necessary services. I understand that SP4Kids is not responsible for erroneous information provided by my insurance company via verbal or insurance website. And that no verbal agreements have been made and this agreement cannot be modified orally. I authorize payment of insurance claims directly to *Sensory Pathways 4 Kids/Kari Shanks Hall, OTR*. Insurance is not payment in full if I owe deductible, copay or coinsurance.
- 3) That I agree to pay the quoted rate, which is not a guarantee of insurance benefits or payment. Any balance not paid in full is subject to a \$35.00 late fee and/or interest of no more than 1.5% monthly. If left unpaid any court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 50% of the outstanding balance.

By signing below, I understand, accept and agree to the financial policy. If credit card provided I Authorize SP4Kids to charge my credit card monthly for any balance due on or after the 20th of each month, after which a statement will be emailed. This includes deductible, copays coinsurance, supplies, consultations, late fees, no shows and any denied services by my insurance carrier. We accept MasterCard, VISA, Discover, American Express and all medical cards. Discounted session* rate (excludes evaluation and FB) available for those without insurance, exhausted benefits or denied claims with credit card on file. If I do not provide my credit card information, I understand no discounts apply.

 Parent/Guardian signature acceptance of financial responsibility & financial agreement Today's Date

 Patient printed name Email for receipt Street# Zip code HSA card?

 Credit Card Number Expiration Cardholder printed name Cardholder signature