



**SIouxLAND CHILD & ADOLESCENT
THERAPY SERVICES, LLC**

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Sioux Falls, SD 57105
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Title XIX (Medicaid) Fee Policy

Siouxland Child & Adolescent Therapy Services, LLC is an enrolled provider of South Dakota Medicaid and will submit the services provided to you to the South Dakota Medicaid Program.

The following are the terms and conditions you must follow:

Insurance Information:

It is your responsibility to provide us with your Medicaid card before each session. If you are under the Medicaid Managed Care Contract, you must also provide us with the referral card from your primary physician, at the time of your first visit.

If you have any other insurance coverage, you must provide us with complete information regarding that insurance. Any explanation of benefits provided to you from your primary insurance must be given to us. If your insurance company does not directly send us an explanation of benefits, it is **your** responsibility to provide us with a copy. Medicaid cannot be billed unless we include an explanation of benefits from your primary insurance.

Failure to provide us with any of the above information will result in a noncompliance of the Medicaid rules, thereby making the services you receive your financial responsibility.

Co-Payments:

All co-payments must be paid at the time of each session. If you are unsure if you have a copayment, please ask and we will inform you.

Non-Covered Services:

The following are charges that, if incurred, will be your sole responsibility. No insurance will be filed for these charges:

-Late Cancellations: Any cancellation with less than 24 hours notice may be billed to you up to the rate of \$170.00/hour, depending on your scheduled service.

-No Shows: Any appointment you do not show up for may be billed to you up to the rate of \$170.00/hour, depending on your scheduled service.

-Ineligibility: If at any time you become ineligible for Medicaid, you will be financially responsible for your account, subject to our full fee of \$170.00/hour.

Summary:

Siouxland Child & Adolescent Therapy Services, LLC will bill Medicaid on your behalf. However, you will become financially responsible if any of the following conditions arise:

- * You do not provide us with your medicaid card prior to receiving service
- * You do not provide us with a purple referral card if you are on managed care
- * You do not provide us with other insurance coverage information
- * You do not provide us with EOB's from your primary insurance
- * You do not provide us with a 24 hour notice for cancellations
- * You do not show up for a previously scheduled appointment

Also, please remember, all co-payments are your responsibility and due at the time of each service.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party

Date: _____

Siouxland Child & Adolescent
Therapy Services, LLC Witness Signature

Date: _____