Midwest Speech Therapy, PC
975 E. Nerge Road, Ste. W20
Roselle, IL 60172
Phone: 224-520-8562

PATIENT AGREEMENT

Midwest Speech Therapy, PC offers speech and language evaluation and treatment services for patients. We require certain information from each patient in order to begin your care. The additionally provided forms need to be completed in order for us to get you started and maintain your records as our patient:

- ☐ Patient Case History Form**
- ☐ Patient Agreement **
- ☐ Healthcare Portability & Accountability Act (HIPAA) Notice of Privacy Practices Acknowledgement**
- ☐ State or Federally Issued Identification Card (Please provide updated for updated copy, if any changes to name or address)
- ☐ Copy of Insurance Identification Card (annually or as insurance coverage changes)
- ☐ Consent to Bill Insurance Form**
- ☐ Consent for Release of Records (if you desire that we discuss patient evaluation results, treatment goals, treatment plan and progress with other therapists, educational/school personnel or medical providers)*

** To be completed every three (3) years unless the forms change with new requirements
*Optional (only if client/parent(s) wish for client's information to be discussed with an outside party)

PAYMENT FOR SERVICES
Each patient is responsible for the payment of their medical (speech/language) services. We gladly bill healthcare payers as a courtesy to our patients and need a copy of your current insurance ID card. If your healthcare insurance payer does not cover particular medical services, you are welcome to make self-pay arrangements at a 40% discount of the usual and customary pricing. We will not post duplicative discounts for both patient payments and insurance contract discounts.

NO SHOW FEES If you are not able to keep your scheduled appointment you need to contact our office or your individual therapist (1) business day in advance. Failure to notify the office or your individual therapist and confirm your cancellation with staff may result in a no show fee. No show fees are required to be paid prior to scheduling future appointments.

ASSIGNMENT OF BENEFITS
My signature on this agreement is my written authorization for Midwest Speech Therapy, PC to submit claims to my identified healthcare payer and receive direct payment for deposit of funds paid on my behalf under my current healthcare coverage. This is a direct assignment of my rights and benefits under my current insurance policy for

Patient or Parent/Guardian Initials ___________

payment of my medical services. I also authorize the release of any information pertinent to my care to my insurance, adjuster or attorney involved in the care and payment of my medical services. This provider has my permission to submit claims or complaints on my behalf to the Illinois Department of Insurance.

BILLING INFORMATION
Our practice does all billing internally including processing claims to healthcare payers, processing client statements and collecting patient balances. We have all the required agreements in place to insure that your protected health information is safe and remains confidential. If you have inquiries about your healthcare claims, monthly statements or if you have additional billing information, you may reach Lacey at either: Office Phone: (224) 520-8562 or Email: Lpeters@mwspeech.com. All patients are responsible for any and all charges not paid for or discounted.

PAYMENT & PAYMENT PLANS
All patients are responsible for any and all charges not paid for or discounted under contract by healthcare insurance payers (Private Health Insurance Carriers, Worker's Compensations, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to reimbursing Midwest Speech Therapy, PC, in a timely manner for the services we provide to you, our valued patient. We accept cash, checks, and credit or debit cards (VISA, Mastercard, Discover Card). We are willing to make reasonable payment arrangements to keep your account current. Please contact our Lacey at (224) 520-8562.

We offer patients the opportunity to make payments on balances over the period of three (3) months following the issuance of the first patient statement. Exceptions can be made to extend the repayment period upon review and approval. Failure to pay on a patient account as agreed is a basis for an account to be assigned to collections for bad debt recovery.

LATE FEES ON PATIENT BALANCES
Our practice charges late fees on unpaid account balances. Following payment/denial reply on your claims from your healthcare insurance payer, we will bill you for the balance of the unpaid portion of your visit. Late fees will begin to accrue on unpaid balances 60 days AFTER we have sent you the 1st statement of the amount that is due. Your account will be charged $15 per month for every month the payment is late AFTER the aforementioned 60 days.

COLLECTION OF PAST DUE ACCOUNTS
We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail or if a patient payment agreement cannot be honored and we are not communicated with to resolve account balances, we may be forced to use the services of a professional collection agency. Once an account is placed with the collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you to discuss any past due accounts.

RELEASE OF PATIENT CLINICAL RECORDS
All release of medical records requires a signed and dated Release of Information (ROI) form with a current date (within 1 year).

PATIENT STATEMENT OF AGREEMENT
This patient agreement and the terms within it are effective for three (3) years from the date of my signature or until the agreement is revised. My signature below signifies that I have read and understand this patient agreement for Midwest Speech Therapy, PC to provide medical/therapy services. I understand and agree to the terms in this patient agreement and intend on complying with them to the best of my ability. I also understand that if I fail to follow the terms of this agreement, I could be cancelled from future services.

Signature of Patient or Parent/Guardian ____Date __________________

Patient or Parent/Guardian Initials __________