Neurology
& Sleep Clinics
of Chicago, S.C.
"Where our patients always come first"

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SERVICES AGREEMENT

Thank you for choosing Neurology & Sleep Clinics of Chicago, S.C. This document is intended to inform you of our policies. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communications and clinical records are strictly confidential except for: **a)** information shared with your Primary Physician and consults, **b)** information (diagnosis and dates of service) shared with you insurance company to process your claims, **c)** information you and/or child or children report about physical or sexual abuse (Illinois State Law requires that this be reported to the Department of Children and Family Services), **d)** where you sign a release of information to have specific information shared and **e)** if you provide information that informs the doctor that you are in danger of harming yourself or others **f)** information necessary for case supervision or consultation and **g)** or when required by law.

E-mails, text messages and social networking sites are not confidential and your doctor may not be able to respond.

Please note that doctors are often not immediately available to take telephone calls. Please leave a message with our staff or voice mail and your doctor will respond to your call after clinic hours. If there is a clinical emergency that you cannot wait for a return call please dial 911 or go to the nearest emergency room.

Laboratory and Test Results: Laboratory and test results are not discussed via telephone calls. All results are reviewed and addressed only during your follow up appointment.

Signature: _____ Date: _____

FINANCIAL/INSURANCE ISSUES: **The clinic visit is the sole responsibility of the patient.** As a courtesy, we will bill your primary and secondary insurance. **We do not bill Worker's Compensation or Accident/Auto Insurance, however, we will accept you as cash payment patient.** We will provide you with any necessary paperwork for you to submit to your worker's compensation/accident/auto insurance. We also are not accepting ***New Medicaid Patient (direct with Medicaid or through Private Insurance.)***

It is the obligation of the patient to know their insurance benefit. This includes, but is not limited to co-pay amounts, number of visits (HMO Coverage), pre-authorization necessity. Payment of any fees, outside the portion covered by insurance, are due at time of service. In the event you have not met your deductible, the full fee is due at each visit until the deductible is satisfied. If your insurance company denies payment or does not cover the visit, we request you pay the balance due at the time. Our cash payment fee is $220.00 for the initial visit and $160.00 for follow up visit. In a case that are fee is greater or less than the fee schedule agreed to with your insurance, you will either be reimbursed or billed for the difference.

Please note that insurance companies require a clinical diagnosis be provided to the insurance with billing. This information may become part of your permanent medical record. If you have any questions regarding this, please speak to your doctor.

48 hours notice of cancellation is required. If cancellation is made after this time, you will be charged, $220.00 for initial visit and $160.00 for follow up visit, cancellation fee. It is understood that an appointment time has been reserved for you and lack of notice prevents sufficient time to schedule other patients. Your insurance company cannot be billed for failed appointment. **You will be responsible of the $220.00 or $160.00 fee.** Payment for the missed appointment is required prior to or the beginning of the next session. ***Note: You will received a call from our staff 48 hrs. prior to your appointment at which time, you can confirm, cancel or reschedule your appointment.***

Account Balances: We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services from our practice. Patients with balances over One Hundred ($100.00) must make payment arrangements prior to future appointments being made. After 60 days, any unpaid balance will be charge 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the patient will be held responsible for any collection fee charged to our office to collect the debt owed.

We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask the office manager. You may have a copy of this form if you requested.

Signature: _____ Date: _____

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician (PCP). Your consent is valid for one year. If you prefer to decline consent, no information will be shared. This authorization maybe revoked at any time.

_____ You may inform my PCP _____ I decline to inform my PCP _____ I do not have a PCP

PHYSICIAN NAME: _____

PRACTICE: _____

ADDRESS _____

PHONE: _____ FAX: _____

NOTICED OF PRIVACY PRACTICES: I have read and received a copy of the Notice of Privacy Practices. May we contact you at home? **YES NO;** May we contact you at work? **YES NO;** May we contact you by cell phone? **YES NO**
Which number would you prefer that we call? _____

Signature: _____ Date: _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ may be treated as a patient of Neurology & Sleep Clinics of Chicago, S.C. It is understood that children over the age of 12 have confidentiality protected by law. We ask for your cooperation to provide opportunity for timely treatment for your child. This consent to treat expires at the end of treatment or if revoked in writing.

Signature: _____ Date: _____