The Whole Child Associates, LLC

15660 Midwest Road, Suite 160
Oakbrook Terrace, IL 60181
Phone 708-975-6065
Fax 630-376-6630
Email janet@thewholechildassociates.com

Thank you for choosing The Whole Child Associates. To assist us in providing excellent service, please provide the information requested below.

Cancellations and Missed Appointments

When you schedule an appointment in our office, that time is reserved. Each therapist is paid by the hour of treatment rendered. When you miss an appointment, without calling to cancel within **24** hours, the therapist does not have the opportunity to offer that time to someone else in need of services. Missed appointments can also interfere with progress in treatment.

It is our policy that families are responsible for all appointments they have scheduled. Families who choose not to attend or call to cancel their appointments after the 24-hour mark are responsible for the missed appointment charge.

The charge is **$75.00 per HOUR** missed/cancelled.

INSURANCE DOES NOT COVER THIS FEE

Fees for missed or cancelled appointments must be paid before the patients next scheduled appointment.

Any patients who miss more than three appointments without 24-hour notice of cancellation are subject to review and may be required to prepay for scheduled sessions or discharged from the practice.

When a client is late for treatment, the client incurs the loss of time, and payment for the full session is expected. Lost time will be billed to the client, as insurance will only be billed for the total treatment time.

Any special circumstances will be submitted for review by the Practice Manager.

ACKNOWLEDGEMENT OF RECEIPT OF THE WHOLE CHILD ASSOCIATES FINANCIAL POLICY

We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call 708-975-6065, if you have any questions.

The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay The Whole Child Associates for all services and supplies provided to you (or the patient, as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payers. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by The Whole Child

Associates in the collection of these charges for examination, evaluation, and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.

Additionally:

- Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) has not been provided.
- If this is an insurance claim, after the insurance has completed processing your claim, you will have **30 days to pay the balance of the charge or make arrangements with our Billing Department (708-975-6065).**
- All patients must have completed "patient registration form" and other forms provided at the time of registration.
- All patients must provide current Occupational Therapy prescription prior to first appointment.
- If you would like us to bill your insurance directly, we **MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD**, otherwise you will be billed.
- Please notify us immediately of any changes in your insurance information or coverage.
- At least 24 hours' notice is required for copies of medical records and there will be a nominal fee.
- You are ultimately responsible for payment of all services.

Insurance Disputes: If there is a dispute regarding your payment of your insurance claim, The Whole Child Associates has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

I understand that it is my responsibility to inform The Whole Child Associates of any desired changes in these authorizations. I assume full responsibility for all items of personal property that I have brought to The Whole Child Associates and release The Whole Child Associates of all liability in the event of loss or damage to such property.

I understand that the Notice of Privacy Practices (NPP) is available at the office. I acknowledge receipt of the The Whole Child Associates Notice of Privacy Practices.

I understand that the office agrees to bill the insurance carrier as a courtesy to me. I must submit information as needed by my insurance company or to The Whole Child Associates to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

I understand that if information is emailed to me, there may be some level of risk that this information could be read by an unauthorized party. By providing my email

address, I am accepting the risks and authorizing The Whole Child Associates, its therapists and staff to communicate with me electronically about my care, my family member's care, my account, The Whole Child Associates products, services, and/or education.

I have received a copy of the HIPPA Privacy Policy for The Whole Child Associates LLC.

I, for myself, or the patient named, hereby consent to such medical evaluation(s) and/or treatment as necessary and appropriate for my condition based on the judgment of my health care provider(s).

The Whole Child Associates LLC receives the right to modify the privacy policy outlined in the notice.

Note: This authorization expires one year after the date of signature.

Signature of Patient/Guardian/Representative **Date**

Name of Patient