FINANCIAL AGREEMENT

THIS AGREEMENT is entered into this _____ day of _____, 20____, by and between Trenka Speech-Language Services, hereinafter referred to as the "Facility," and _____, hereinafter referred to as "Patient," and _____, hereinafter referred to as "Financial Responsible Person."

PATIENT CARE

The Facility shall provide services and materials in compliance with the orders of Patient's attending physician. Administration of Therapy Treatments will be delivered as ordered by said physician.

PAYMENTS

Patient and Financial Responsible Person agree jointly and separately to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient and to pay such charges as they become due.

Patient and Financial Responsible Person further agree that if the services rendered by Facility to Patient are covered by insurance, or benefits under either Title XVIII or Title XIX of the Medicare Act (Medicare/Medicaid), it is nevertheless the joint obligation of Patient or Financial Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Financial Responsible Person further agree that any co-insurance or deductible obligation under Medicare, Medicaid, or private insurance must be paid by Patient or Responsible Person.

1. Patient responsibility is due upon receipt of insurance explanation of benefits (EOB). Because it is extremely impractical or difficult to ascertain all items of damage or amounts thereof which would be sustained by Facility as a result of an account becoming delinquent, Patient and Financial Responsible Person agree that any charges which are not paid in FULL when due shall be subject to a late fee. If balance remains unpaid 30 days after date of EOB a late fee will be charged and account may be transferred to collections. Should Patient's account be referred to an attorney for collection, Patient and Financial Responsible Person agree to pay, in addition to all sums due, all reasonable attorney's fees, court costs, and all reasonable costs of collection.
2. Patient certifies and warrants that all information submitted by him/her for purposes of applying for or receiving benefits under Title XVIII or Title XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Financial Responsible Person agree to indemnify and hold harmless Facility from and against any and all loss, damage, cost, expenses or liability resulting from Patient's submission of false or incorrect information to Facility. The Patient authorizes any health care facility or doctor to furnish to Facility and/or the Social Security Administration, its fiscal intermediaries or carrier all requested information from Patient's medical or financial records. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any person or entity which is or may be liable under contract to Facility, Patient, or to a family member or employer of Patient to pay all or a portion of the costs of care provided to Patient, including, but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carrier, welfare fund or Patient's employer. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any independent auditor of Facility. Patient requests that payment of authorized benefits be made to Facility on his behalf.
3. Facility does not make any assurance of any kind whatsoever that Patient's care will be covered by Medicare/Medicaid or private insurance companies, and the Patient and Financial Responsible Person hereby release Facility, its agents, servants and employees from any liability or responsibility in connection with the Patient's and/or Financial Responsible Person's potential claim of coverage under Medicare/Medicaid or insurance companies.
4. In this agreement, whenever the context so requires, the masculine gender includes the feminine and/or neutral and the singular number includes the plural.

THE PATIENT AND FINANCIAL RESPONSIBLE PERSON CERTIFY THAT EACH OF THEM HAS READ THIS AGREEMENT AND RECEIVED A COPY THEREOF AND UNDERSTANDS AND AGREES TO ALL THE PROVISIONS IN THIS AGREEMENT.

THE FINANCIAL RESPONSIBLE PERSON OR OTHER PERSON WHO SIGNS THIS AGREEMENT ON BEHALF OF AND IN THE PLACE OF THE PATIENT REPRESENTS THAT HE IS AUTHORIZED BY PATIENT TO DO SO, AND THE ABOVE-NAMED PATIENT AND FINANCIAL RESPONSIBLE PERSON

SIGNING THIS AGREEMENT AGREES BY SO SIGNING TO ACCEPT ALL OF THE TERMS HEREOF AND TO PERFORM ALL OBLIGATIONS HEREUNDER. THERE ARE NO REPRESENTATIONS MADE BY FACILITY OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAN ARE SET FORTH IN THIS AGREEMENT.

AGREEMENT TO TREAT

This agreement is entered into this _____ day of _____, _____ by and between Trenka Speech-Language Services herein referred to as the "Facility," and _____, hereinafter referred to as "Patient Representative."

1. The facility welcomes all persons without regard to race, color, national origin, religion, sex, or qualified handicaps.
2. The Facility shall provide services and materials in compliance with the orders of Patient's attending physician. Administration of treatments will be ordered by said physician.
3. Consent for Treatment: Patient and Patient Representative acknowledge that Patient is under the medical treatment and care of said attending physician, and that the Facility renders its services to Patient under the general and specific instructions of said physician. Patient and Patient Representative recognize that said physician furnishing services to Patient is an independent Contractor and is not an employee or agent of Facility.
4. Restrictions and Liabilities: The Facility shall incur no liability for injuries of any kind suffered by Patient while under its care, therefore should the Patient discontinue treatment before the attending physician has so ordered Patient, Patient and Patient. Representative agree to assume all responsibility for all results which may follow.
5. Facility is not liable for injury to Patient caused by visitors attempting to assist or treat Patient in any way. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted in Patient treatment areas.
6. The Facility shall not be responsible for personal belongings left in the Facility.
7. Gender in this agreement, whenever the context so requires, the masculine gender includes the feminine and/or neutral and the singular number includes the plural.
8. The patient and patient representative certify that each of them has read this agreement and received a copy thereof and understands and agrees to all the provisions in this agreement.
9. The Clinic may take photographs and/or videos of the Patient necessary for identification and/or medical purposes at any time during the Patient's Therapy Program. The Patient has the right to privacy. Photographs and/or videos cannot be used for any other purposes without the Patient's express written permission

The patient representative, or other person who signs this agreement on behalf of and in the place of the patient represents that he is authorized by patient to do so, and the above names patient and each patient representative signing this agreement agrees by so signing to accept all the terms hereof and to perform all obligations hereunder. There are no representatives made by facility or any of its employees or agents other than is set forth in this agreement.

HIPPAA PRIVACY POLICY

Trenka Speech Language Services is required by law to keep your health information safe. This information may include: notes from your doctor, teacher, or other health care provider; your medical history; your test results; treatment notes; and insurance information

We are required by law to provide you with a copy of our privacy notice upon request. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

CONSENT TO DISCLOSE MEDICAL RECORDS

The Patient authorizes Trenka Speech-Language Services or physicians to furnish to the Social Security Administration or their agents, and all fiscal intermediaries and carriers all requested information from the Patient's medical or financial records.

The Patient authorizes Facility to disclose all or any part of the Patient's medical or financial records to any person or entity which is or may be liable under contract to Facility, to the Patient, or to a family member or employer of the Patient to pay all or a portion of the cost of care provided to the Patient, including, but not

limited to, hospital or medical service companies, health care companies, insurance companies, Worker's Compensation carriers, welfare funds, or the Patient's employer or the Facility's auditors.

APPOINTMENT POLICIES AND OTHER CLINIC EXPECTATIONS

1. Appointments are scheduled into available standing appointment slots. Once you have been scheduled into an appointment time, the therapist has committed this time to you.

2. If you are unable to keep a scheduled appointment, you must give ample notice (within 2 hours of the appointment time). Any cancellation with less than 2 hours' notice, including no show appointments will be charged a $35.00 fee. Please be advised that we will not bill your insurance for these fees since most health plans do not cover charges of this nature. This means that you will be held responsible for payment. These fees are due at the time of your next scheduled visit.

3. Should your child be sick (fever over 100, vomiting, diarrhea, shortness of breath, chronic cough, COVID-19 exposure or positive test within 10 days, etc.), please cancel your appointment to keep our clinic a safe environment for all those who enter and to avoid spreading illnesses.

4. If your child is seen at their preschool or daycare, and your child is not in attendance on the scheduled day of therapy, it is your responsibility to contact the therapist to inform of a cancelation for that day. Should you neglect to contact the therapist, then the no show policy and fee will be charged to you.

5. Because insurance benefits vary, it is suggested that you check with your insurance company regarding benefits for speech therapy and if there is any authorization required.

6. As in accordance with clinic policy and for the respect of other patients, no children (other than those being treated by the therapist) are allowed in the gym or treatment rooms. Please keep any visiting children in the waiting area.

Please feel free to discuss any special circumstances with the therapist. Thank you for choosing Trenka Speech-Language Services, we are pleased that you and/or your physician have chosen us to help you with your treatment and rehabilitation.

The signatures below represent the participants' agreement to FINANCIAL RESPONSIBILITY, AGREEMENT FOR TREATMENT, HIPPAA PRIVACY POLICY, CONSENT TO DISCLOSE MEDICAL RECORDS, AND APPOINTMENT POLICY/OTHER CLINIC EXPECTATIONS.

Date	PATIENT/GUARDIAN
Date	RESPONSIBLE PARTY/PATIENT'S AGENT
Date	WITNESS