2019 IL App (1st) 180161-U

No. 1-18-0161

Order filed May 2, 2019

Fourth Division

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT

ILLINOIS NEUROSPINE INSTITUTE, P.C.,	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellant and Cross-Appellee,	)	Cook County
	)	
v.	)	No. 16 L 6277
	)	
LUCIOUS HARDING,	)	Honorable
	)	James E. Snyder,
Defendant-Appellee and Cross-Appellant.	)	Judge presiding.

JUSTICE BURKE delivered the judgment of the court.
Presiding Justice McBride and Justice Gordon concurred in the judgment.

ORDER

¶ 1 *Held*: In this breach of contract case, we affirm the circuit court's judgment following trial in awarding plaintiff $42,569.72 where the court's judgment was not against the manifest weight of the evidence and it properly found the contract between the parties was valid and enforceable.

¶ 2 Defendant, Lucious Harding, came to plaintiff, Illinois Neurospine Institute, P.C., in need of medical treatment due to an injured back and neck, which was the result of being involved in a motor vehicle accident. At defendant's initial appointment with plaintiff, he signed multiple documents, including one titled "Financial Responsibility Statement," which made him

personally responsible for paying for the medical treatment. Following a course of treatment, plaintiff sued defendant for breach of contract, alleging that, despite performing close to $170,000 worth of treatment, it had not been paid anything. The case proceeded to trial, where defendant raised the defense that the Financial Responsibility Statement was unconscionable. Following a bench trial, the circuit court found the Financial Responsibility Statement to be valid and enforceable and awarded plaintiff $42,569.72 in damages, or approximately one-quarter of the claimed damages.

¶ 3 Both parties have appealed the circuit court's judgment. Plaintiff contends that the court erred by not awarding it the full amount of its claimed damages, and defendant contends that the court erred by not finding the Financial Responsibility Statement to be unconscionable. For the reasons that follow, we affirm the court's judgment.

¶ 4 I. BACKGROUND

¶ 5 A. Pre-Trial

¶ 6 In February 2015, defendant, while in his vehicle, was rear-ended by a truck. As a result of the accident, defendant began suffering from back and neck pain. The following month, defendant had an initial consultation at plaintiff's office with neurosurgeon Dr. Ronald Michael, who then treated defendant over the course of the next several months.

¶ 7 In June 2016, plaintiff sued defendant for breach of contract. According to the complaint, on March 18, 2015, defendant signed plaintiff's written agreement, whereby defendant would be financially responsible for all medical treatment provided to him. Plaintiff asserted that defendant knew the services he received were non-gratuitous and plaintiff would bill him for such services. Plaintiff claimed that it treated defendant in various manners and thus, completely fulfilled its obligations under the contract, but had yet to be paid $169,102.18 from him. Plaintiff

sought as damages the amount allegedly owed by defendant, 5% in pre-judgment interest and court costs.[1]

¶ 8 Plaintiff attached to the complaint the written agreement at issue, which was a one-page document titled "Financial Responsibility Statement." There were six headings that were underlined and bolded, but the heading most relevant for this appeal was the "Payment Guarantee," which stated: "For and in consideration of services rendered by ILLINOIS NEUROSPINE INSTITUTE, patient (responsible person) hereby agrees to and guarantees payment of all charges incurred for the account of the patient." Other headings related to consent for treatment, consent to release information, Medicare patients and the assignment of insurance benefits. The final heading was "Agreement to Pay Balances," which stated:

> "In the event that said medical insurance coverage is not sufficient to satisfy the charge in full, patient (responsible person) acknowledges that the remaining balance is not covered by this assignment and agrees to be fully responsible for the payment of any balance due. For any non-contracted insurance carriers, ILLINOIS NEUROSPINE INSTITUTE will submit a courtesy claim and if no payment is receive in sixty (60) days, the balance will become patient responsibility. Patient (responsible person) acknowledges responsibility for any expenses incurred by ILLINOIS NEUROSPINE INSTITUTE for collecting any of the charges on the account of the patient.

[1] At trial, plaintiff orally sought, and received, leave from the circuit court to amend its complaint to withdraw the request of 5% pre-judgment interest.

> In the event charges are not paid, due to authorization or pre-certification denials, patient acknowledges the charge is considered a non-covered service and agrees to be fully responsible for payment of any balance due."

The Financial Responsibility Statement bore a signature appearing to be that of defendant with the date March 18, 2015.

¶ 9 Defendant filed an answer to the complaint and denied that he personally owed plaintiff any money for medical treatment. Defendant highlighted a patient billing ledger dated two weeks after plaintiff filed its complaint, which showed that defendant owed "$0.00." Additionally, defendant asserted as an affirmative defense that plaintiff's claim was subject to the Illinois Health Care Services Lien Act (Lien Act) (770 ILCS 23/1 *et seq.* (West 2016)).

¶ 10 During the course of litigation, defendant moved for summary judgment, in part on the basis that plaintiff could only pursue the amount allowable under the Lien Act and that the Financial Responsibility Statement was procedurally and substantively unconscionable. The circuit court denied his motion, finding that the Lien Act still allowed a medical care provider to pursue payment for its reasonable charges and that there were questions of fact that needed to be resolved in order to determine whether the Financial Responsibility Statement was unconscionable. The case eventually proceeded to a bench trial.

¶ 11 B. Trial

¶ 12 At trial, plaintiff presented one witness, Dr. Ronald Michael, its owner and sole neurosurgeon. Dr. Michael testified that plaintiff was a neurosurgery clinical practice focusing on issues of the spine. In discussing his neurosurgery clinic, Dr. Michael stated that he did not bill Medicare, Medicaid or private insurance companies, and relied almost exclusively on workers' compensation and personal injury work. With workers' compensation, he was

compensated through the employer's workers' compensation insurance. With personal injury work, he was generally compensated through the liable party's insurance carrier. According to Dr. Michael, he would file a lien against the patient's potential settlement or verdict so that the patient understands he is ultimately liable for the payment. But Dr. Michael asserted that he also waited until the patient's case was resolved before expecting payment and if he was not paid, he would "pursue the patient" if the economics made sense. Dr. Michael acknowledged that, in this case, he sued defendant before the personal injury case was resolved because defendant's attorney indicated to Dr. Michael that defendant "wasn't going to pay." Dr. Michael further acknowledged that, under the Lien Act, plaintiff's allotted portion based on the eventual settlement of defendant's personal injury lawsuit was $44,829.52. Dr. Michael asserted that, based on his understanding of the law, he was allowed to pursue the remaining amount owed.

¶ 13 Dr. Michael identified Plaintiff's Exhibit No. 1 as the Financial Responsibility Statement, a document that all of his prospective patients were required to sign. The document was part of an "entry packet" his prospective patients would receive, which also included various privacy notices and a diagram where they could document where their pain was located. According to Dr. Michael, the purpose of the Financial Responsibility Statement was so prospective patients understood that they were responsible for paying him for the medical services, though he agreed that nowhere in the document is there a timeframe by which a patient must pay a bill. If someone refused to sign the document, Dr. Michael would not accept that person as a patient. Instead, he would either help the person find another physician or send the person back to his or her referring physician.

¶ 14 Dr. Michael testified that Plaintiff's Exhibit No. 1 contained defendant's signature and the date March 18, 2015, and he recalled being with defendant when he signed the document. Dr.

Michael also stated that he "asked [defendant] if he understood what he was signing" and "if he had any questions." However, on cross-examination, defendant's attorney asked Dr. Michael if he had been asked during a deposition: "And you don't remember asking him any specific questions or saying anything specifically to him about that packet?" Defendant's attorney then asked if he had given the answer: "No. Again, it's more for them than for me. So if we're ready to move on, we move on." Although Dr. Michael attempted to remark that his deposition testimony was taken "out of context," he ultimately testified that "[i]t's not how I understood it," in reference to apparently not understanding the question during his deposition.

¶ 15 Although plaintiff had additional employees, Dr. Michael oversaw all of plaintiff's billing. Dr. Michael used a fee schedule which listed the price for any procedure or service he may perform or provide, a document he had maintained since 1993 and periodically adjusted for inflation. Each procedure or service corresponded to a unique current procedural terminology (CPT) code, which was standard across the medical community. According to Dr. Michael, he would "begin" the process of billing and then send "it off" to a third-party billing company. Dr. Michael explained that, after performing a procedure, he would "dictate an operative report" including the proper CPT codes so that "a procedure has a fee attached to it." Based on his experience as an expert witness, which often required him to opine on the reasonableness of other doctors' fees and viewing itemized lists of costs from other medical professionals after the conclusion of personal injury cases as well as consulting other resources, Dr. Michael knew "intuitive[ly]" how his fees compared to other members of the medical community. Based on this background, Dr. Michael testified that his costs were reasonable.

¶ 16 Dr. Michael next identified Plaintiff's Exhibit No. 2 as "the account history" of defendant, which was a spreadsheet that included the dates of services, CPT codes representing

the procedures performed, the fees associated with those procedures and a total bill. The history began on March 18, 2015, with what Dr. Michael described as an initial consultation of defendant associated with CPT code 99245, which cost $567.46. Dr. Michael then described his second visit with defendant on April 1, 2015, wherein he gave defendant an epidural steroid injection. These were the only two dates of service that Dr. Michael specifically discussed in relation to Plaintiff's Exhibit No. 2. The total amount listed on defendant's account history was $169,102.18, spanning services and procedures from March 18, 2015 through October 14, 2015. Dr. Michael asserted that defendant had not paid plaintiff for any of these services. Dr. Michael agreed that he did not send defendant periodic bills showing a running total of what he owed, but explained that "[t]he [billing] software doesn't do that." Instead, Dr. Michael's third-party billing company would send a bill for each service date showing the total cost for the specific procedure or procedures that date. Dr. Michael believed that defendant's lawyers should have received these bills.

¶ 17 Dr. Michael testified that, in addition to giving defendant epidural steroid injections, he performed a discogram, which was a diagnostic procedure, a disk decompression and a biacuplasty—a procedure wherein radio frequencies were transmitted into defendant's spinal disk. According to Dr. Michael, his treatment of defendant was mostly conservative, as opposed to more aggressive treatment such as a fusion surgery. Based on Dr. Michael's treatment, defendant reported vast improvement.

¶ 18 Dr. Michael next identified Plaintiff's Exhibit No. 3, which was a group of documents, as his "treatment records" of defendant. Dr. Michael testified that the treatment records corresponded with the account history in Plaintiff's Exhibit No. 2. Although Dr. Michael agreed that the documents did not contain a copy of any bills sent to defendant, he explained that he

personally did not send the bills and instead that was the responsibility of the third-party billing company. Dr. Michael also agreed that he did not produce the bills in connection with the case, but asserted that "we don't maintain them," as they were maintained by the third-party billing company. Dr. Michael, however, reiterated that he had produced a summary of the bills. Plaintiff eventually admitted all three exhibits into evidence.

¶ 19 Regarding defendant, Dr. Michael agreed that he did not have any information on whether defendant could pay his medical bills other than with the possible proceeds from his personal injury case and understood the case to be a " 'policy limits' " case. During their initial consultation, Dr. Michael did not tell defendant about his fee schedule, something he would have done had defendant asked, and Dr. Michael had no way of knowing what exactly the fees would ultimately amount to based on treating defendant. Dr. Michael agreed that neither he nor defendant knew at the time of their initial consultation that the total amount of fees would be close to $170,000. But Dr. Michael acknowledged that, by late August 2015, when defendant's first major procedure was to occur, he knew he would eventually perform four major procedures on defendant, with each costing approximately $40,000. And Dr. Michael agreed that he never told defendant how much each procedure would cost and what the total bill could eventually become. Dr. Michael reiterated, though, that defendant never "inquired" about the costs.

¶ 20 On cross-examination, Dr. Michael identified Defendant's Exhibit No. 1 as a "Billing: Patient Ledger" for defendant sent to plaintiff by its third-party billing company. The ledger was dated July 7, 2016, with Dr. Michael's name on the bottom of the document and total charges listed of $169,621.24. According to Dr. Michael, the document represented all the appointments he had with defendant except for one appointment in May 2017, where defendant wanted to discuss disability issues, but he did not charge defendant for this visit. Dr. Michael agreed that

the top of the document referenced Scottsdale Insurance Company (Scottsdale), who he knew was the insurance company of the vehicle that struck defendant's vehicle. In the document, Dr. Michael agreed that there were rows titled "Patient Aging" and "Insurance Aging" with columns of timeframes: 0-30 days, 31-60 days, 61-90 days, 91-120 days and over 121 days. Under each timeframe associated with the "Patient Aging" row, it showed that defendant owed $0 and thus, owed $0 in total. Under the "Insurance Aging" row, it showed $519.06 for 61-90 days and $169,102.18 for over 121 days, and thus, $169,621.24 in total. Dr. Michael acknowledged that, based on this document, defendant's medical bills were being booked as the responsibility of Scottsdale. But Dr. Michael explained that this meant Scottsdale would pay defendant and then defendant would pay him.

¶ 21 On the itemized portion of the document, there were several columns titled "Service Date", "Charges", "Ins[urance] Balance", "Pat[ient] Resp[onsibility]", "Pat[ient] Payment" and "Pat[ient] Balance." Under each "Service Date" there were rows depicting the various dates Dr. Michael treated defendant. Dr. Michael acknowledged that all the rows under patient responsibility, patient payment and patient balance showed $0, whereas there were charges in each row under insurance balance. Dr. Michael explained that, although the third-party billing company understood defendant's treatment was based on a personal injury case, sometimes employees at the billing company populated the costs for services under the insurance column and sometimes under the patient column. Dr. Michael, however, was adamant that, "under no circumstances," does this "mean that the patient doesn't have a balance."

¶ 22 Dr. Michael continued discussing Defendant's Exhibit No. 1, specifically the itemized portion of the document, where he agreed that he performed four main procedures on defendant

on August 28, September 16, September 30 and October 14, 2015, each billed at approximately $40,000 and together representing the bulk of his fees.

¶ 23 The defense presented its case, with its sole witness, defendant, who testified that he had dropped out of high school, but obtained a GED. Defendant was referred to Dr. Michael by a therapist. Defendant recalled his initial appointment with Dr. Michael, where he was "in pain" and in need of treatment. Defendant stated that he gave plaintiff's secretary his "medical card," who in return handed him three or four sheets of paper. No one explained to him the documents, and no one told him he would be personally responsible for paying the medical bills. Defendant assumed that plaintiff would be paid from the proceeds of his personal injury lawsuit, possibly a "settlement," and that his personal injury lawyers would "take care of all of that." At the time he began his appointments with plaintiff and ever since, defendant was unemployed due to the motor vehicle accident. During defendant's course of treatment, no one discussed the medical bills with him and no one gave him an estimate of the costs associated with any of the treatment. Defendant had no idea his medical bills would reach approximately $170,000, an amount of money he had never even had in his lifetime. Defendant testified that, had he known the eventual cost of his treatment, he would have attempted to find alternative treatment options.

¶ 24 While under the care of Dr. Michael, he and defendant discussed treatment options. According to defendant, Dr. Michael recommended fusion surgery, but defendant did not want to undergo such an invasive procedure, so the two discussed other options, including a biacuplasty, which he ultimately underwent. Defendant also acknowledged undergoing a disk decompression and receiving steroid injections. By the time Dr. Michael finished treating defendant, he had not "personally" received one bill from plaintiff itself, Dr. Michael himself or a third-party billing company. Defendant acknowledged that his personal injury case eventually settled and that the

proceeds of the settlement had been "distributed" to various people, including himself, but he was unaware if his doctors had been paid. Following the testimony of defendant, he admitted Defendant's Exhibit No. 1 into evidence.

¶ 25 During closing argument, plaintiff contended that, through Dr. Michael's testimony and its documentary evidence, it proved that it provided various medical services and procedures for defendant and they were reasonable in cost. In particular, plaintiff highlighted Dr. Michael's testimony, wherein he stated that each service listed in Plaintiff's Exhibit No. 2 corresponded to records in Plaintiff's Exhibit No. 3. As such, plaintiff concluded that its evidence showed it was entitled to the full amount requested in its complaint. Plaintiff also asserted that there was no evidence that its contract with defendant was unconscionable, in part because his own testimony showed he had a choice in the treatment options.

¶ 26 Defendant responded, contending that the parties entered into the contract on an uneven playing field with defendant being handed a stack of documents, including the Financial Responsibility Statement, but Dr. Michael never asked him any questions about it. Defendant posited that the contract was unconscionable given the manner in which he signed the document and the surrounding circumstances. Defendant also highlighted that he was never told by Dr. Michael how much any of the procedures would cost or that he would be personally responsible for those costs, and thus, Dr. Michael never gave him an opportunity to object to any of the treatments. Defendant concluded that the Financial Responsibility Statement was unenforceable as a matter of law, and therefore, he owed plaintiff nothing. Defendant also pointed out that there was no evidence that he ever received a single bill from plaintiff, and in fact, the patient billing ledger showed that he owed $0 for the medical services. As such, defendant asserted that there

was "no proof" that he owed any money on any bill or that he had the responsibility for paying for the medical treatment.

¶ 27 Following argument, the circuit court concluded as a preliminary matter that, based on Plaintiff's Exhibit No. 1, there was a valid and enforceable contract entered into between the parties. After acknowledging that there was no dispute that Dr. Michael performed medical services for defendant and had not been paid any money for them, the court asserted that the question before it came "down to proofs." And based on the court's attempts to "match[]" services performed from the records in Plaintiff's Exhibit No. 3 with the account history of defendant from Plaintiff's Exhibit No. 2, specifically "to the extent to which" it could find "any reference to a [CPT] code," it found that Dr. Michael and defendant had an initial consultation, Dr. Michael gave defendant "certain epidural steroid injections" on various dates and "certain treatments" occurred on August 28, 2015. In light of its findings, the court determined the amount of fees proven by plaintiff was $42,569.72. The court accordingly entered judgment in favor of plaintiff in that amount.

¶ 28 Plaintiff appealed that judgment, after which defendant cross-appealed.

¶ 29 II. ANALYSIS

¶ 30 A. Plaintiff's Appeal

¶ 31 Plaintiff contends that the circuit court erred in awarding it only $42,569.72, rather than its requested amount of $169,102.18, where Dr. Michael testified the full amount represented the reasonable costs of the medical services provided to defendant and that amount was reflected in Plaintiff's Exhibits Nos. 2 and 3.

¶ 32 Plaintiff's one-count complaint pled a breach of contract claim, which has four elements that must be proven. *Razor Capital v. Antaal*, 2012 IL App (2d) 110904, ¶ 30. First, there must

be a valid and enforceable contract. *Id.* Second, the plaintiff must have performed its part of the contract. *Id.* Third, there must have been a breach by the defendant. *Id.* And finally, the plaintiff must have suffered damages as a result of the breach. *Id.* Plaintiff's appeal concerns the final element, specifically the amount of the resulting damages. "A plaintiff must prove damages to a reasonable degree of certainty, and evidence cannot be remote, speculative, or uncertain." *Dowd & Dowd, Ltd. v. Gleason*, 352 Ill. App. 3d 365, 383 (2004). The plaintiff not only has the burden to prove that it has suffered damages, but also a rational basis for the computation of the damages. *Kay v. Prolix Packaging, Inc.*, 2013 IL App (1st) 112455, ¶ 33.

¶ 33 In a bench trial, the circuit court, as the trier of fact, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford to their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47. Because the circuit court is in a superior position to that of the reviewing court to make these determinations, we give heavy deference to its findings of fact. *Id.* As such, we will not disturb its findings unless they are against the manifest weight of the evidence, which occurs "only if the opposite conclusion is apparent or if the finding appears to be arbitrary, unreasonable or not based on the evidence." *Id.*

¶ 34 In this case, plaintiff relies on Dr. Michael's testimony along with Plaintiff's Exhibit Nos. 2 and 3. Plaintiff's Exhibit No. 2 was defendant's account history with dates of services, CPT codes representing the procedures performed, the fees associated with those procedures and a total bill. Plaintiff's Exhibit's No. 3 was a group exhibit consisting of defendant's treatment records. Although not discussed in detail at trial by Dr. Michael, the circuit court noted that, while some of the documents in Plaintiff's Exhibit No. 3 were relevant to the treatment of defendant by Dr. Michael, many documents were irrelevant. For instance, there were records

from other doctors' treatment of defendant and results from an MRI and laboratory testing of defendant that were not performed by Dr. Michael. But there were several documents titled "Operation Note" detailing various procedures performed by Dr. Michael on defendant, including the biacuplasty, the disk decompression and multiple epidural steroid injections. And based on our review of these documents, every service date listed in Plaintiff's Exhibit No. 2 has a corresponding Operation Note of the same day, except for March 18, 2015, the day of the initial consultation. Though, there is a letter included in Plaintiff's Exhibit No. 3 from Dr. Michael to another doctor dated March 18, 2015, in which Dr. Michael remarked that he had a "neurosurgical consultation" with defendant that day.

¶ 35 But merely because the Operation Notes and letter included in Plaintiff's Exhibit No. 3 corresponded to dates of service listed on Plaintiff's Exhibit No. 2 does not mean the court's judgment was against the manifest weight of the evidence. For one, plaintiff never produced any actual bills sent to defendant for medical treatment. But more importantly, in Plaintiff's Exhibit No. 2, there are CPT codes and fees associated with each service date yet in the corresponding Operation Notes and letter in Plaintiff's Exhibit No. 3, these codes are nowhere to be found. And at trial, plaintiff never presented any evidence of what each CPT code stood for except the one (99245) associated with Dr. Michael's initial consultation with defendant. Instead, at trial, Dr. Michael merely testified that CPT codes were unique to each procedure and service, standard in the medical community, and he maintained a fee schedule associated with each procedure and service. Though the Operation Notes and letter undoubtedly detail various procedures and services performed by Dr. Michael on defendant, which assuredly came at great costs, plaintiff failed to sufficiently connect all of the CPT codes and associated fees listed in Plaintiff's Exhibit No. 2 with the narratives included in Plaintiff's Exhibit No. 3. Because of this failure and

regardless of whether the medical fees were reasonable, plaintiff failed to prove a reasonable basis for all of the claimed damages (see *Kay*, 2013 IL App (1st) 112455, ¶ 33; *Dowd & Dowd*, 352 Ill. App. 3d at 383), as the circuit court aptly observed when it noted this case came "down to proofs." Plaintiff simply did not meet its burden to prove all of its claimed damages, and we therefore cannot say the opposite conclusion is apparent, or the court's finding is arbitrary, unreasonable or not based on the evidence.

¶ 36 Nevertheless, plaintiff argues that Dr. Michael testified to performing all the services and procedures listed on Plaintiff's Exhibit No. 2 and his testimony was uncontradicted, which, according to plaintiff, means the circuit court was required to rule in its favor for the full claimed amount of damages. It does not follow, however, that merely because a witness testified without being contradicted, his testimony must be accepted by the trier of fact. Instead, the trier of fact has the responsibility to weigh evidence and determine witness credibility. *Walker*, 2015 IL App (1st) 133788, ¶ 47. Because of this role, the trier of fact may accept or reject as much or as little of a witness's testimony as it wishes and "give whatever weight it deems appropriate to the evidence submitted." *Northwestern Memorial Hospital v. Sharif*, 2014 IL App (1st) 133008, ¶ 26. And here, the circuit court clearly accepted parts of Dr. Michael's testimony as it related to plaintiff's exhibits, but also found that plaintiff did not sufficiently prove the full amount of the claimed damages. The court therefore exercised its role as the trier of fact properly. Plaintiff further argues that the circuit court erred in rejecting Plaintiff's Exhibit No. 3 as evidence of its services rendered to defendant. The court did not outright reject Plaintiff's Exhibit No. 3 as evidence of services rendered by plaintiff to defendant, but rather found that plaintiff failed to sufficiently connect the CPT codes and associated fees in Plaintiff's Exhibit No. 2 with the

narratives in Plaintiff's Exhibit No. 3. Consequently, the circuit court's judgment of $42,569.72 in favor of plaintiff was not against the manifest weight of the evidence.

¶ 37 B. Defendant's Cross-Appeal

¶ 38 In defendant's cross-appeal, he contends that the circuit court erred in finding the Financial Responsibility Statement between him and plaintiff was a valid and enforceable contract and instead, argues that the contract was both procedurally and substantively unconscionable. Defendant posits that the circumstances surrounding the contract's formation demonstrate that the contract was unconscionable, especially because no one explained to him the consequences of signing the contract, no one told him that he would be personally responsible for paying for the medical services, and no one disclosed at the very least an estimate of what the fees would be prior to any medical service.

¶ 39 There are two types of unconscionable contracts: procedurally unconscionable contracts and substantively unconscionable contracts. *Phoenix Insurance Co. v. Rosen*, 242 Ill. 2d 48, 60 (2011). A procedural unconscionability analysis examines the process of contract formation whereas a substantive unconscionability analysis examines the contract itself. *Id.* A procedurally unconscionable contract is where there was "some impropriety during the process of forming the contract depriving a party of meaningful choice." (Internal quotation marks omitted.) *Id.* In determining whether a contract was procedurally unconscionable, we look at "whether each party had the opportunity to understand the terms of the contract, whether important terms were hidden in a maze of fine print, and all of the circumstances surrounding the formation of the contract." (Internal quotation marks omitted.) *Id.* We also consider the relative bargaining power of the parties. *Razor v. Hyundai Motor America*, 222 Ill. 2d 75, 100 (2006).

¶ 40 A substantively unconscionable contract is where the contract itself was so one-sided that it was a patently unfair agreement. *Phoenix Insurance,* 242 Ill. 2d at 60. "Indicative of substantive unconscionability are contract terms so one-sided as to oppress or unfairly surprise an innocent party, an overall imbalance in the obligations and rights imposed by the bargain, and significant cost-price disparity." *Kinkel v. Cingular Wireless LLC,* 223 Ill. 2d 1, 28 (2006) (quoting *Maxwell v. Fidelity Financial Services, Inc.*, 184 Ariz. 82, 89 (1995)). A finding that a contract is unconscionable may be based on either procedural unconscionability, substantive unconscionability or some combination of both. *Id.* at 21. Whether a contract is unconscionable is a question of law, and as such, we review the issue *de novo*. *Id.* at 22. However, to the extent there are questions of fact surrounding the formation of the contract, those are reviewed under the manifest-weight standard. *In re Marriage of Woodrum*, 2018 IL App (3d) 170369, ¶ 86.

¶ 41 Initially, defendant posits that, because his relationship with Dr. Michael was a fiduciary one, there is a presumption that their contract was unenforceable. Illinois law is clear that a fiduciary relationship exists between a doctor and his patient (see *San Roman v. Children's Heart Center, Ltd.*, 2010 IL App (1st) 091217, ¶ 14), and generally, where "a fiduciary relationship exists and where the dominant party benefits from execution of the document by the subservient party, a presumption of invalidity arises." *Prueter v. Bork,* 105 Ill. App. 3d 1003, 1006 (1981). However, we cannot find that the Financial Responsibility Statement was presumptively invalid for three reasons. First, prior to defendant signing the document, there was no doctor-patient relationship and therefore, it cannot be said that they had a fiduciary relationship when executing the contract. Rather, the Financial Responsibility Statement itself established the fiduciary relationship. Second, none of the cases cited by defendant supporting his proposition that the contract was presumptively invalid involved anything like the situation in

this case of a patient paying for medical services. *Staude v. Heinlein*, 414 Ill. 11 (1953), involved a woman who transferred real estate to her niece before her death. *In re Estate of Feinberg*, 2014 IL App (1st) 112219, involved a complex trusts and estates lawsuit with allegations of misappropriation of assets. *Khan v. BDO Seidman*, LLP, 408 Ill. App. 3d 564 (2011), *aff'd sub nom. Khan v. Deutsche Bank AG*, 2012 IL 112219, involved a lawsuit based on fraudulent investment advice which allegedly allowed investment professionals to exact exorbitant commissions and fees. And lastly, *Paskas v. Illini Federal Savings & Loan Association*, 109 Ill. App. 3d 24 (1982), involved money being disbursed to a joint bank account owner to the detriment of the other account owners. That is to say, all of these cases involved allegations of improper self-dealing or fraud. None of the fact patterns of these decisions are remotely comparable to what has occurred in the present case. And third, plaintiff did not benefit from the Financial Responsibility Statement to the detriment of defendant. See *Tummelson v. White*, 2015 IL App (4th) 150151, ¶ 19 ("A fiduciary may not profit *at the expense* of the party dominated.") (Emphasis added.) Rather, the contract was mutually beneficial, as defendant would receive medical treatment for his back and neck injury, and in return, pay for those services, as is the case with nearly every doctor-patient relationship. Given these reasons, we do not agree with defendant that the Financial Responsibility Statement was presumptively invalid.

¶ 42 Having determined that no presumption of invalidity applies to the Financial Responsibility Statement, we now examine whether the contract was procedurally unconscionable. Having reviewed the document, the critical provision was under a bolded and underlined heading titled "Payment Guarantee" and stated that: "For and in consideration of services rendered by ILLINOIS NEUROSPINE INSTITUTE, patient (responsible person) hereby agrees to and guarantees payment of all charges incurred for the account of the patient."

This provision was not part of a complex or lengthy legal document consisting of legalese, but rather was part of a one-page document with words in normal-sized font presented in layman's terms with a title that should have tipped off any person to its importance. See *Kinkel*, 223 Ill. 2d at 26 (agreement found procedurally unconscionable where terms were presented in fine print in language that the average consumer might not fully understand). What is clear from the "Payment Guarantee" provision is that the patient is the one ultimately responsible for guaranteeing payment for medical services.

¶ 43 While there was conflicting testimony about where defendant signed this document, *i.e.*, in the presence of Dr. Michael himself or rather a secretary, and if Dr. Michael asked defendant specifically if he understood the document, there was no evidence presented that anyone intimidated defendant into signing the document or rushed him along in the process of reading and signing the document. It is true that, based on defendant's testimony, he was in pain during his initial appointment with Dr. Michael, and we have sympathy for defendant's condition. But it is not as if defendant came to Dr. Michael with a medical condition that needed to be treated urgently, such as a heart attack, where a patient literally would not be able to refuse treatment without risk of death. Although defendant's condition and pain may have resulted in some disparity in bargaining power, there was no evidence that Dr. Michael or anyone under his employ exacted any compulsion on defendant to sign the contract. See *Zerjal v. Daech & Bauer Construction Inc.*, 405 Ill. App. 3d 907, 913-14 (2010) (where "the plaintiffs were under no economic or other compulsion to sign" a contract, that was evidence that the contract was not unconscionable). Nothing prevented defendant from reading the one-page Financial Responsibility Statement to understand its terms, asking questions of Dr. Michael before signing the document or even choosing a different doctor. Furthermore, while defendant did not graduate

high school and Dr. Michael graduated from medical school, nothing about their comparative educational attainments and any resulting disparity in bargaining power can overcome the other evidence weighing in favor of a valid and enforceable contract.

¶ 44 Still, defendant argues that the Financial Responsibility Statement was a contract of adhesion, sometimes referred to as a take-it-or-leave contract (see *Keefe v. Allied Home Mortgage Corp.*, 393 Ill. App. 3d 226, 232 (2009)) and therefore, it was procedurally unconscionable. While some contracts of adhesion are found to be unconscionable, our supreme court has stated that "[i]t cannot reasonably be said that all such contracts are so procedurally unconscionable as to be unenforceable" given how prevalent they are in modern life. *Kinkel*, 223 Ill. 2d at 26. And merely because the party who prepared the contract has a "superior bargaining position" and does not allow another party "to negotiate any terms, does not mean that" the contract "is unconscionable." *Williams v. Jo-Carroll Energy, Inc.*, 382 Ill. App. 3d 781, 786 (2008). Instead, there must be "some fraud or similar wrongdoing" in order to render a contract unconscionable. *Id.* In this case, while the Financial Responsibility Statement was nonnegotiable, there was no evidence presented of any fraud or legal wrongdoing by plaintiff or Dr. Michael in conjunction with the contract formation. While perhaps as a matter of medical ethics or transparency in billing, Dr. Michael *should* have explained to defendant during that initial visit that he would personally responsible for paying the medical services, shown defendant his fee schedule and estimated a total cost for his medical services, these failures do not mean that the Financial Responsibility Statement was unconscionable at its formation. And here, there was no impropriety during the process of signing the Financial Responsibility Statement that deprived defendant of a meaningful choice. See *Phoenix Insurance*, 242 Ill. 2d at 60.

¶ 45 Lastly, defendant's reliance on *Dubey v. Public Storage, Inc.*, 395 Ill. App. 3d 342 (2009) to support his procedural unconscionability argument is unpersuasive. There, this court found a storage rental agreement unconscionable where, in part, the storage company's manager took approximately five minutes to discuss the agreement with the plaintiff, and the plaintiff did not have time to read each provision of the contract. *Id.* at 353. This court also emphasized that, despite the manager knowing that the plaintiff wanted to store "a washer and dryer, a refrigerator, a basketball hoop, and other large items," the manager withheld from the plaintiff that the agreement stated that she could only store up to $5,000 worth of belongings and the company's liability would be limited to that amount. *Id.* Thus, in *Dubey*, in addition to the plaintiff being rushed into signing the rental agreement without an opportunity to read all of its provisions, the manager knew that the plaintiff would be storing more than what the rental agreement allowed. Conversely, in the present, there was no evidence presented that defendant was prevented from reading the six provisions of the Financial Responsibility Statement or any impropriety like what occurred in *Dubey* based on the manager's knowledge of what the plaintiff would be storing. Consequently, plaintiff's Financial Responsibility Statement was not procedurally unconscionable.

¶ 46 Lastly, we examine whether the contract was substantively unconscionable. Nothing in plaintiff's Financial Responsibility Statement shows that the terms therein, particularly the "Payment Guarantee" provision, were so one-sided to oppress or unfairly surprise defendant. The essence of the obligations imposed by the contract was that plaintiff would provide medical services to defendant, and in return, defendant would be responsible for paying plaintiff. We cannot fathom how it would surprise defendant that he would be personally liable for the

payment of medical services rendered by plaintiff or how this arrangement was oppressive. Consequently, plaintiff's contract was not substantively unconscionable.

¶ 47 In sum, where the Financial Responsibility Statement was neither procedurally unconscionable nor substantively unconscionable, the circuit court properly found the contract to be valid and enforceable.

¶ 48 III. CONCLUSION

¶ 49 For the foregoing reasons, we affirm the judgment of the circuit court of Cook County.

¶ 50 Affirmed.