

Kabir Center for Health & Rehabilitation
"Change your Habits, Change your Health, Change your Life!"

2412 E. Washington St. Ste 9A, Bloomington, IL 61704

Office 309-663-7011 Fax 309-663-4806

www.kabircenter4health.com

Office Policies

- *On your initial visit payment is due in full at the time of service*, unless prior arrangements were made. This fee can vary, depending on clinical necessity, from \$45 - \$225. As a courtesy we DO accept insurance assignment, but NOT until we are able to contact your insurance carrier directly to verify benefits. If the services rendered today are verified to be covered by insurance and your insurance company pays us, your account will be either credited by the amount of insurance payment or reimbursed to you upon request.

Based on the above, *payment today will be paid by:* **Cash **Check** **Credit Card****

- After your initial visit, and if you have verified insurance benefits and your deductible has been met we will bill the insurance carrier and collect only a co-payment or co-insurance fee from you.
- We are a fee for service practice, and therefore expect payment at the time of service. For your convenience you can make one payment at the beginning of the week, or pre-payment.
- We do file with Medicare, however do not accept assignment. Payment is expected at the time of service and Medicare will pay you directly, unless other arrangements have been made.
- If you must cancel and reschedule an appointment, please try to do so within 24 hours of your appointment. Two consecutively missed appointments can result in a consultation with the doctor to discuss your commitment to care. Should you discontinue care for any reason other than discharge by the doctor, any balances will become immediately payable in full, regardless of claims submitted.
- This clinic does not promise that an insurance company will pay. Insurance companies pay health costs according to fee schedules, which they have devised. The fee schedule may or may not coincide with the actual fees that are charged. Although insurance companies call their schedules "USUAL, CUSTOMARY AND REASONABLE"; they are often, in fact, based on information and averages of charges gathered from 1 to 3 years ago. Therefore, in most cases, **WHAT A DOCTOR CHARGES MAY BE HIGHER THAN WHAT THE INSURANCE COMPANY PAYS**. This does not mean that the doctor is overcharging. It means that the insurance company pays what they may have agreed to pay (per a contract), or pay based on statistical averages, **NOT WHAT IS CHARGED**.
- Since we do not own your insurance policy and may occasionally experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying the situation.
- By signing below, you agree that any balance over \$500 or over 30 days may be subject to additional collection fees until the account is paid in full.
- If office collections are necessary, I hereby grant this office permission to seek all legal means necessary to collect any and all monies legally due them for services rendered, as well as compensation for all fees incurred during this process.

By signing, I understand and agree to comply with each of the policies outlined above.

Name (please print)

Signature

Date

Witness Signature

Date

Dear Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help better serve you, please complete the following information. We look forward to working with you to build better health for your family.

PEDIATRIC HISTORY FORM

Today's Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Name of Parents/Guardians: _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Left Handed Right Handed

Address: _____

City: _____ State _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Who referred you to our office, or how did you hear about us? _____

Purpose for contacting our office? _____

Addressing the Issues that Brought Your Child to the Office

Briefly describe your main concern. *If you're here for wellness care please go to #11* _____

1) If you are experiencing a symptom, is it... (check more than one if necessary to describe your problem)

- Sharp Dull Burning Numbness & Tingling Pressure Comes & Goes Travels
- Constant

2) Where is the symptom? _____

3) When did the symptom first start? _____

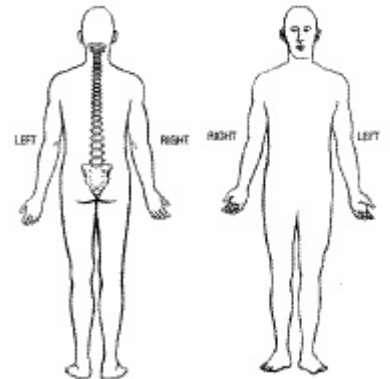
4) Since the symptom started, it is...
 About the same Getting Better Getting Worse

5) What makes it worse: _____

6) Yes, it interferes with: Work Sleep Walking
 Sitting Hobbies Leisure

7) Does this cause you to be: Irritable Moody Worried

8) Is your Condition: Job Related Auto Accident Home Injury



Please outline on the diagram the area of your discomfort.

9) Other Doctors seen for this problem and when (please list):

Chiropractor _____ Medical Doctor _____ Other _____

10) Drugs you now take: _____

11) Past Surgeries / Operations _____

Check any of the following conditions your child has suffered from during the past six months:

- Ear infections Scoliosis Seizures Headaches Asthma/Allergies
- Digestive Problems ADD/ADHD Recurring Fevers Colic Growing/Back Pains
- Bed Wetting Car Accident Temper Tantrums Chronic Colds Other: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Are you satisfied with the care your child has received there? Yes No

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total during Lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ Total during Lifetime: _____

Please list: _____

Please, list your child's vaccination history:

Prenatal History:

Were there complications during pregnancy? No Yes, Explain:

Birth Intervention: Forceps Vacuum Extraction Caesarian Section (Emergency or Planned)

Were there complications during the delivery? No Yes, Explain:

Birth Weight: _____ Birth Length: _____

Feeding History:

Breast Fed: No Yes; How long? _____

Formula Fed: No Yes; How long? _____

Developmental History:

Is / has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? No Yes; List:

Has your child been involved in a car accident? No Yes; Explain:

Has your child experienced any other traumas not described above? No Yes; Explain:

I hereby authorize this office and its Doctors to administer care to my child, as they deem necessary.

Parent/Guardian Signature

Date

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PATIENT HEALTH INFORMATION CONSENT FORM FOR MINOR CHILD

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of these records for the care given proper to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

• I give permission to the following individuals to have information regarding my medical condition or billing and insurance information (i.e. parent/guardian's name, spouse, etc.):

First Name

Last Name

Relationship

• I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Printed Name of Minor Child

Parent/Guardian Signature

Date