

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 New Patient,

It is our 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 us serve you better, please complete the following information. We look forward to working with you to build better health for you and your family.

PERSONAL INJURY QUESTIONNAIRE (MVA) / PERSONAL INFORMATION

Today's Date: _____ Date of Accident: _____
Name: (Last) _____ (First) _____ (MI) _____
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: _____
Employer at time of Accident: _____ Occupation: _____
Brief job description: _____
Employer Address: _____
Dates Employed: from: _____ to: _____
Have you been off work because of this accident? Yes No If yes, dates from: _____ to: _____
Marital Status: M W D S Spouse's Name: _____
Spouse's Employer: _____ Spouse's Occupation: _____
Spouse's Employer Address: _____
Spouse's Work Phone: _____ Spouse's Mobile Phone: _____
Children's Names and Ages: _____
Who referred you to our office, or how did you hear about us? _____
Have you had previous chiropractic care? Yes No If Yes, when was your last visit? _____
If you stopped, why did you stop? _____
For how long were you receiving adjustments? _____ How often did you go? _____
Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods were used? _____

PURPOSE FOR CONTACTING US

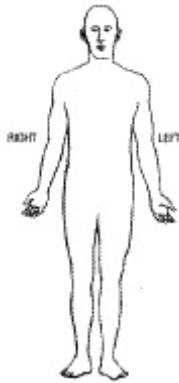
List your chief complaint(s) in order of severity: **[Pain Intensity Scale: 1 - 10; with 1 = least & 10 = greatest]**

1. Area of pain: _____ Frequency: intermittent occasional frequent constant
Pain intensity: minimal mild moderate severe Intensity varies between: _____ & _____
Pain start date: _____
Pain is aggravated by: _____
Pain is relieved by: _____
Pain is better in: AM Mid-day PM Pain is worse in: AM Mid-day PM
Pain does not change with time of day Pain is: improving getting worse unchanged
Have you had similar symptoms in the past? Yes No If yes, please explain: _____

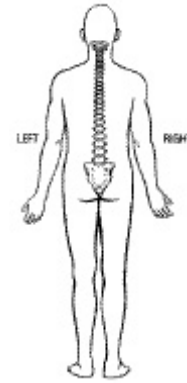
2. Area of pain: _____ Frequency: intermittent occasional frequent constant
Pain intensity: minimal mild moderate severe Intensity varies between: _____ & _____
Pain start date: _____
Pain is aggravated by: _____
Pain is relieved by: _____
Pain is better in: AM Mid-day PM Pain is worse in: AM Mid-day PM
Pain does not change with time of day Pain is: improving getting worse unchanged
Have you had similar symptoms in the past? Yes No If yes, please explain: _____

3. Area of pain: _____ Frequency: intermittent occasional frequent constant
Pain intensity: minimal mild moderate severe Intensity varies between: _____ & _____
Pain start date: _____
Pain is aggravated by: _____
Pain is relieved by: _____
Pain is better in: AM Mid-day PM Pain is worse in: AM Mid-day PM
Pain does not change with time of day Pain is: improving getting worse unchanged
Have you had similar symptoms in the past? Yes No If yes, please explain: _____

Pain Drawing: Please use the following drawing to mark where and what type of pain and sensations you are experiencing. If your pain is intermittent (coming and going), then mark the drawing as if the pain were present. Use the symbols in the box to indicate the type of pain or sensations you are feeling.



- | | |
|-------|----------------|
| ///// | Stabbing pain |
| >>> | Aching pain |
| XXX | Burning pain |
| = = = | Numbness |
| oooo | Pins & Needles |



Use the codes listed to indicate your ability to perform the following activities. Simply mark the appropriate code letter(s) in the space next to the activity.
 CODES: U = unable P = painful D = difficult L = limited N = normal

- | | | |
|---|---|---|
| <input type="checkbox"/> Coughing or sneezing | <input type="checkbox"/> Climbing | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Getting in or out of car | <input type="checkbox"/> Balancing | <input type="checkbox"/> Dressing self |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Stooping |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Gripping | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Walking short distances | <input type="checkbox"/> Pulling | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Sitting at a table | <input type="checkbox"/> Sexual function | <input type="checkbox"/> Lying on back |
| <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Bending over forward | <input type="checkbox"/> Lying on side (knees bent) |

Use the codes listed to indicate if you have had &/or are currently experiencing any of the following symptoms. Simply mark the appropriate code letter(s) in the space next to the activity.
 CODES: P = past &/or C = current

- | | | |
|---|---|--|
| <input type="checkbox"/> Blurring vision | <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Headaches:
Area of head: _____
How often: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Loss of bowel function | <input type="checkbox"/> Confusion | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Loss of bladder function | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Stomach difficulty | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Frequent urination | |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Asthma | |

List other doctors that were consulted for these conditions and/or symptoms:
 1. _____ 2. _____ 3. _____

Previous diagnosis given: _____

List operations and date of operations:
 1. _____ 2. _____ 3. _____

List serious illnesses/conditions you have had &/or are currently experiencing (please mark as P=past &/or C=current):
 1. _____ 2. _____ 3. _____

Do you have a pacemaker? Yes No

If female:
 Is there any chance you are pregnant? Yes No
 Number of pregnancies? _____
 How many healthy births (if any)? _____
 Number of miscarriages/terminated pregnancies? _____

Have you ever been diagnosed with cancer? Yes No If yes, please explain: _____

List any medications you currently take: _____

Father, Mother, Brother, Sister, Children with any similar problems? Yes No If yes, then whom and what conditions: _____

List all broken bones: _____

Are you a smoker Yes No If yes, how many cigarettes per day? _____ How long have you been smoking? _____

Are you an alcohol drinker? Yes No If yes, how often? rarely socially heavy

Are you engaged in regular exercise? Yes No If yes, what types of exercise? _____

Describe the accident: _____

Did anyone witness the accident? Yes No

The other cars approximate speed _____

Place of accident (address) _____

Name of street you were traveling on: _____ Time accident occurred: _____

Direction vehicle(s) were traveling (N S E W) _____

Make, model and year of **your** vehicle: _____

Does your vehicle have an automatic transmission? Yes No

Make, model and year of **the other** vehicle: _____

What were the weather conditions (rain, snow, sun, fog, etc.) _____

What was your position in the vehicle? driver passenger

If driver, how far from the steering wheel were you sitting (measure if possible) _____

If passenger, were you sitting in: front right rear left rear

Did your vehicle strike another vehicle? Yes No

Was your car struck by another vehicle? Yes No

Was the impact from the: front right side left side rear?

Did your vehicle strike another vehicle after 1st impact? Yes No

Did you realize that you were about to be struck? Yes No

Did you have time to prepare yourself for impact? Yes No

At the time of impact, were you: looking straight forward looking right looking left?

Were both hands on the steering wheel? Yes No

Was your foot on the brake? Yes No

Before the accident, was the headrest: up down?

After the accident, was the headrest: up down?

Were you braced for impact? Yes No

Where in the car were you after the accident? _____

Were you wearing your seat belt? Yes No Were you wearing the lap belt? Yes No Did seat back break? Yes No

Did you strike anything in the vehicle at time of impact? Yes No If yes, specify (steering wheel, dash, windshield, etc.) _____

Please state the part of your body that struck the above mentioned (i.e. head, arm, legs, etc.) _____

Did the airbag deploy? Yes No

Immediately following the accident, how did you feel? _____

Were you unconscious? Yes No Were you in a daze? Yes No

Did you go the hospital? Yes No

If yes, how were you transported? Ambulance Private Transportation

When did you get to the hospital? Immediately 1-3 hrs. later 4-12 hrs. later Days later -- how many? _____

Did ambulance attendants place you in: Neck Collar: Yes No

Splints: Yes No

Brace: Yes No

Name of Hospital: _____

Attended by Dr: _____

Were x-rays taken related to this accident? Yes No

Was a C.T. scan taken? Yes No

List any other lab work or diagnostics performed due to this accident _____

Were you admitted to the hospital? Yes No If yes, how long were you there? _____

What treatment was rendered? _____

What recommendations were made? _____

Were you advised to: See your Primary Physician See Orthopedic Specialist Go to Physical Therapy Neurologist Other

List any other medical facilities you visited because of this accident (immediate care, primary physician) _____

List all pervious trauma(s) and date of trauma(s) _____

List any other auto / work accidents and dates and briefly describe accident, injuries and Drs. consulted

1. _____

2. _____

Were any doctors consulted due to the above listed *previous* accident(s)? Yes No

If yes, doctor's name _____ Office location _____

List any military injuries _____

List all known allergies _____

Is your pain, from the accident, constant? Yes No Is your pain on and off? Yes No

How is the pain worsened? standing bending sitting coughing sneezing straining

Does it hurt to rise from a: sitting position lying position?

Is your pain: sharp stabbing burning aching?

List any other feelings you are experiencing _____

Do you have any numbness or tingling in your (check boxes for what applies) legs feet toes arms hands fingers?

What is your most **COMFORTABLE** position? sitting lying on your right side left side stomach back standing other
If other, please explain _____

Do you have a firm mattress? Yes No

Do you have trouble changing positions in bed? Yes No

Does stretching and twisting worsen the pain? Yes No

Do any of the following relieve your pain? heating pad hot bath ice packs hot shower

If you have tried a brace, does it relieve the pain? Yes No

Does a change in shoes or heel height worsen the pain? Yes No

Do you feel better moving around? Yes No

Do your knees ache or hurt? Yes No

Do you have cramps in your legs arms other? _____

Has there been a change in your bowel habits? Yes No

BEFORE THE ACCIDENT – Estimate your total lifting ability:

How much weight? Maximum _____ Average _____

How far could you carry this weight? _____ How long? _____

Was this lifting done at work? Yes No If no, where? _____

How often did you carry this amount of weight? _____

AFTER THE ACCIDENT – Describe your total lifting ability:

How much weight? with pain _____ with out pain _____

Did you experience this pain, if any, before your accident? Yes No

What limitations do you feel you have due to the accident? _____

How far can you carry the above stated weight? _____

What symptoms does lifting produce? _____ How long do they last? _____

Are you presently able to **LIFT VERY HEAVY** _____ **LBS.**

LIFT VERY LIGHT _____ **LBS.**

Are you presently able to **WORK VERY MUCH** _____ **HRS.**

WORK VERY LITTLE _____ **HRS.**

In what positions can you work with a **MINIMUM DEMAND** of physical effort? standing sitting walking

With minimum demand of physical effort can you: walk stand sit?

Can you work in a sitting position with some degree of walking or standing activity? Yes No

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work? Yes No

Generally speaking, is your inability to perform these functions due to: pain weakness structural limitations nerves

Do you have normal sexual function? Yes No

Are you able to take care of you personal self, such as dressing, bathing, etc.? Yes No

Do you need assistance with the above? Yes No

Do you feel your present condition is temporary? Yes No

Do you feel your present condition is permanent? Yes No

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, and please provide details (i.e. Tuberculosis, Hepatitis, etc.) _____

I verify that the above questionnaire has been answered truthfully and completely to the best of my ability.

Patient's signature: _____ Date: _____

DOCTOR'S NOTES

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PATIENT HEALTH INFORMATION CONSENT FORM

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:

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 Patient

Signature

Date