

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 INFORMATION

Today's Date: _____
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: _____ Occupation: _____
Marital Status: M W D S Spouse's Name: _____
Children's Names and Ages: _____
Who referred you to our office, or how did you hear about us? _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

<u>Childhood Years</u>	Yes	No	Unsure	Comments (if any)
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any falls from a height over 3 feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine's such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any form of abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>Adulthood</u> – (18 to present)	Yes	No	Unsure	Comments (if any)
Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you play adult / extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your level of stress (1 = none / 10 = extreme) Occupational _____ Personal _____

Which answer best describes your own current ideas and values toward health?

- TREATMENT ONLY – I only consult a doctor when I have problems/symptoms and discontinue as soon as the symptoms leave.
- EARLY DETECTION – In addition to symptom relief, I see dr.'s occasionally to detect problems early before they become serious.
- PREVENTION – I'm conscious about my health, diet, exercise and actively pursue these because I feel and perform better.
- WELLNESS – I actively inform myself about true health and I am concerned with the long-term effects of things on my health.

Have you ever:

- Bought bottled water: Yes No
- Joined a health club: Yes No
- Consumed vitamins or supplements: Yes No

To help us better explain chiropractic as it applies to your health and life and how we may be able to help you, please check the one best answer for each statement below:

- 1) I remember important things in my life by what I... See Hear Feel
- 2) The primary reason I brush my teeth is to... Avoid tooth decay and gum disease Make sure I have healthy teeth and gums
- 3) When I make decisions I generally... Gather the facts and weigh the evidence Make the right choice instantly
 Consult my friends and family Depends on how I feel about it

Each of us must balance a variety of demands on our time, money and emotions. Please rate the following items, in order, relative to their importance to you with a (1) being the most important and (7) being the least important.

____ Marriage ____ Automobile ____ Job ____ Health ____ House ____ Kids ____ Pet

Addressing the Issues that Brought you 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
 Other: List _____

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: _____

What times of day are the symptoms worse: _____

6) Yes, it interferes with:

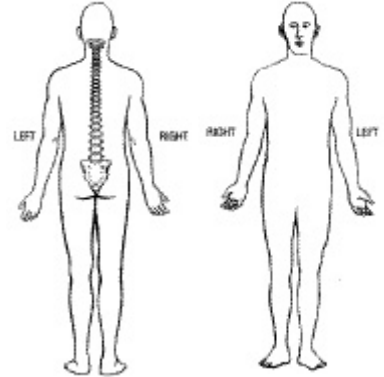
- Work Sleep Walking
 Sitting Hobbies Leisure

7) Does this cause you to be:

- Irritable Moody Worried

8) Is your Condition:

- Job Related Auto Accident Home Injury
 Physical Illness Emotional Illness Chemical Exposure
 Pregnancy/Childbirth



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:

- Over-the-Counter Pain Relievers Prescription Pain Medications Muscle Relaxer
 Blood Pressure Medicine Insulin Other _____ None

11) Past Surgeries / Operations _____

Please check () all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pin & needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | |

12) Personal Care: You use the following on a regular basis:

- Hair Spray Cologne Perfume Deodorant Antiperspirant Cosmetics
 Eye Drops Scented Soap / Detergent Dryer Fabric Scent Fluoridated Products Ammonia
 Clorox

13) You do the following on a regular basis:

- Jog Run Swim Walk Bicycle Garden Yoga Meditation Breathing Exercises
 Aerobics Weight Training

14) Do you have strong cravings for particular foods? List _____

Are there foods you avoid: _____

15) Dietary Intake:

Breakfast Yesterday: _____

Lunch Yesterday: _____

Snacks Yesterday: _____

Dinner Yesterday: _____

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

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

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