Robbins Headache Clinic

2610 Lake Cook Road, Suite 160
Riverwoods, IL 60026
Office: (847) 374-9399
Office@RobbinsHeadacheClinic.com

Rev. 3-25

Billing Policy

Initial visit: $330
Follow up visits: $170 or higher.
Botox administration: $350-$375 per visit + cost of product if not supplied by your insurance.

Blood work: If drawn in our office, we will charge per lab test ordered. Our charges are often very affordable compared to other lab facilities.

Service Fee: $35 fee may apply to the following: prior authorization/appeal for medications, call/emails that require Dr. Robbins and or Dr. Ivins to significantly adjust medications and or/treatment plan, school forms, FMLA/Disability paperwork, copies of chart records/itemized bills. With your permission, we will have your credit card number on file. You will receive a receipt via email/text. If not available, we will bill you for these services. **I authorize Robbins Headache Clinic to store and use my credit card on file or bill me for these services.**

Patient Name (Print): _____

Signature: _____ Date:_____

Insurance: We do not directly bill any commercial insurance and are often considered out-of-network. You may submit our superbill to your insurance company for reimbursement, however we cannot guarantee any payment from your insurance. Medicare patients will pay at the time of service, and our office will bill on your behalf, and you may receive a reimbursement check within the month. We do not accept Medicaid at this time.

*Prices are subject to change, depending on the length of time spent with each patient.

*Payment is requested at the time of visit. We accept Visa, Mastercard, Discover, Apple Pay, HAS, and flex spending cards.

*There is NO charge for routine refills of medications, if within your appointment follow up time frame.

This information has been acknowledged by the patient.

Patient Name (Print): _____

Signature:_____ Date:_____

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Medication Policy Guidelines

During the course of your treatment, various medications will be recommended in hopes of alleviating your headaches/medical condition. Some of these are approved for other medical purposes, but not approved for treatment of headaches, but we can use them off label. Please inform us if you do not feel comfortable taking a medication. We will fully customize your treatment plan to personalize you.

We or the pharmacy will provide you with materials such as package inserts, brochures, or other similar materials regarding the medication. Certain medications may incur some risks with driving, such an inducing sleepiness. If you have any decreased alertness, or any problem with fatigue or sleepiness due to the medications, we urge you not to drive while under the influence of that medication.

If you are pregnant, or if there is a chance of you becoming pregnant, please let us know immediately, and DO NOT take any medication. We will discuss other medication options with you.

MRI / CT Scan Policy

We may recommend an MRI of the brain for every new headache patient, depending on the history and symptoms. If this is too claustrophobic, or you cannot otherwise undergo the MRI, we would recommend other options. We may recommend that a returning headache patient undergo an MRI/CT scan of the brain at intervals and/or for any significant changes in symptoms or patterns. We cannot guarantee that the brain scan would determine if there is a tumor or other abnormality. Once the scan is performed, a radiologist will read your images and provide us with a written report. We do not review the actual images here at the office.

The above information is acknowledged by patient.

Patient Name:_____Date:_____

Signature: _____

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SUMMARY NOTICE OF PRIVACY PRACTICES (HIPPA)

The following information is a summary of the NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If the notice is changed in any material way, a revised notice will be available upon request.

We will use your medical information for treatment. For example, a nurse who is providing your care will report any changes in your condition to your doctor. We will use your medical information for payment. For example, we may need to give your insurance plan information about your diagnosis, treatment and the supplies used. We may contact you at any phone number or address you have provided to us to remind you of an appointment or other health care matters or to obtain payment for our services.

We may disclose your medical information to the family members you have assigned, or others who are involved in your care or for the payment for that care. You must notify our designee in writing if you do not want us to communicate with you in any of these ways.

We may use your medical information for any uses that are required or permitted by law. Other uses and disclosures will be made only with your written authorization. You may cancel an authorization at any time by notifying our designee in writing.

You have the following rights: Right to privacy notice; Right to request restrictions on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and Right to an accounting of disclosures of your medical information.

Contact Information: If you feel that your privacy rights have been violated, please contact Dr. Lawrence Robbins at (847) 374-9399, or the U.S. Secretary of Health and Human Services.

As indicated by my signature below, I hereby acknowledge receipt and understanding of the Notice of Privacy Practices.

Patient Name:_____ Date:_____

Signature: _____

You may disclose my medical information to:_____

(Name and relationship to patient)

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PATIENT CONTACT PERMISSION AGREEMENT

Date: _____

I, _____, give the Robbins Headache Clinic doctors and staff permission to contact me or other healthcare providers as follows:

By Phone: [ ] okay to leave a voice message that may contain medical information [ ]

By Text: [ ] okay to leave a text message that may contain medical information [ ]

By Email: [ ] okay to leave an email message that may contain medical information or attachments [ ]

By Mail: [ ] okay to send a letter that may contain medical information [ ]

By FAX: [ ] okay to send a FAX that may contain medical information [ ]

Signature _____

Print Name _____