Robbins Headache Clinic

2610 Lake Cook Road, Suite 160
Riverwoods, IL 60026
Office: (847) 374-9399
Fax: (847) 374-9393
Email: RobbinsHeadache847@gmail.com

Billing Policy

Initial visit costs $280 and follow up visits are $140 or higher.

If blood work is indicated there will be an additional fee.

Botox administration fee is $350-$375 per visit.

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 and Apple Pay.

There is a $30 cancelation fee if you cannot keep your appointment and have not informed our office the day prior to your appointment by 3:00pm. We are very understanding that life happens, but please also be respectful of other patients wanting to get into our office for an appointment.

Patient Name (Print): _____

Signature: _____ Date:_____

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Service Fee Policy

Why do we charge extra fees?

Due to an increase in overhead, we have recently instituted modest fees for select services. Many other offices charge for phone calls and paperwork, charging significantly more than the amounts listed below. This policy is effective May 16, 2019.

Which services will have a fee and what is the cost?

$30 fee may apply to the following:

- Prior authorizations and/or appeals
- Calls/emails that require Dr. Robbins or Brooke Phenicie, NP-C to significantly adjust medications and/or treatment plan.
- School forms
- FMLA forms
- Disability forms
- Copies of chart records/itemized bills
- Cancellation of appointment in under 4 hours or a no-show to your appointment.

*There is NO charge for routine refills of medications.

How are the charges made and is there a receipt?

With your permission, we will have your credit card number on file through the "Square" system in which 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 the above services.

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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. We will provide you with as much information as we can in regards to the safety and possible risks of these medications, Many of these medications used for headache are not officially approved by the FDA for headache. They are approved for other purposes, but used for headaches. We will provide you with materials such as package inserts, PDR (Physician desk reference) materials, or other similar materials regarding the medication,

As far as pregnancy, if you are pregnant, or if there is a chance of you becoming pregnant, please let us know, and DO NOT take any medication. We will discuss the medication options available to you.

Certain medications for 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.

Again, side effects of each medication will be discussed, and materials presented. Please inform us if you do not want to take a medication, or any particular medication, due to possible adverse events, We will then avoid medication, or that particular medication.

The above information was discussed with the patient.

Patient Name:_____ Date:_____

Signature: _____

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MRI / CT Scan Policy

We may recommend an MRI of the brain for every new headache patient, depending on the history and symptoms. If the too claustrophobic, or cannot otherwise undergo the MRI, we would recommend other options.

We may recommend that all returning headache patients undergo an MRI/CT scan of the brain at intervals and or for any significant changes in symptoms and patterns of their headaches.

We cannot guarantee that the brain scan would see if there was a tumor or other abnormality. While it has been our experience that many patients want to postpone an MRI of the brain due to various reasons, we will clearly discuss with each patient the safety and benefits of obtaining one.

Once the scan is performed, a radiologist will read your films and provide us with a written report. We do not review the actual images here in at the office.

This information has been reviewed with the patient and acknowledged.

A copy will be kept in the patient's chart.

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 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)