reboot center
FOR INNOVATIVE MEDICINE™

P 360 331 2464
F 866 277 7173

5492 MYRTLE AVE | PO BOX 554
FREELAND WA 98249

INFO@REBOOTCENTER.COM
REBOOTCENTER.COM

PEDIATRIC DEMOGRAPHIC & BILLING INFORMATION

I. Patient Information

Full name: _____ Other past or present given names: _____

Child goes by: _____ Date of birth: _____/_____/_____ Gender: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Please designate a primary email address and **primary phone number** at which we can leave confidential communications regarding appointments, your child's health care, and other important information:
Confidential email address*: _____ **Confidential phone number:** _____
*Please note: Unless specifically requested otherwise, appointment confirmations and other confidential health information will be communicated to the **designated confidential email address**.

With whom does the child live?

_____

Who has legal custody?

_____

School/Daycare:

_____

Whom may we thank for referring you?

_____

Child's primary care physician:

_____

II. Parental Information

Mother's Information:
Name: _____
Maiden name: _____
DOB: _____/_____/_____
Address: _____
City: _____
State: _____ Zip: _____
Home phone #: _____
Employer: _____
Occupation: _____
Work phone #: _____
Email address:_____

Father's Information:
Name: _____
DOB: _____/_____/_____
Address: _____
City: _____
State: _____ Zip: _____
Home phone #: _____
Employer: _____
Occupation: _____
Work phone #: _____
Email address:_____

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III. Emergency Contact (not residing at the same address)

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Mobile: _____

IV. Billing Information

Does your child's insurance plan have naturopathic and alternative medicine benefits? **Yes No**

Does the plan require that you designate a PCP? **Yes No** If yes, please take the necessary steps to list the child's Reboot Center provider(s) with your insurance carrier so that we can bill according to your contract.

Is a referral required in order to receive coverage? **Yes No** If yes, list referring provider and clinic name:

_____

Primary Care Provider (if not a Reboot Center provider): _____ Clinic phone: (___) _____

PCP Clinic address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company & Plan Name: _____

ID#: _____ Group/Policy#: _____ Co-pay: _____

Name of policy holder _____ Policy holder's date of birth: _____/_____/_____

Policy holder's address: _____

Relationship of policy holder to patient: _____ Policy holder's gender: _____

Is the Primary Insurance Policy a (*circle*): POS PPO EPO HMO Other: _____

Secondary Insurance Company & Plan Name: _____

ID#: _____ Group/Policy#: _____ Co-pay: _____

Name of policy holder _____ Policy holder's date of birth: _____/_____/_____

Policy holder's address: _____

Relationship of policy holder to patient: _____ Policy holder's gender: _____

Is the Secondary Insurance Policy a (*circle*): POS PPO EPO HMO Other: _____

Guarantor Information

This section must be completed by the person financially responsible for the child's account.

Guarantor's last name: _____ Guarantor's first name: _____

Date of birth (required): _____/_____/_____ Gender: _____ Email address: _____

Mailing address: _____

Home phone number: _____ Mobile number: _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient. I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 2% per month. I further

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understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any

fees generated as a result of collection efforts. I understand that some third-party payers may require that some medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Reboot Center to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, STDs, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Guarantor's Signature: _____ Today's date: _____

Non-Covered Service/Supply Billing Agreement

The services and/or supplies listed below may be classified by your medical insurance company as not medically necessary and/or investigational. These services and/or supplies are not insurance reimbursable. If your Reboot Center provider incorporates one or more of these procedures, services or supplies into the treatment program for your dependent, you must pay for them yourself and not seek reimbursement from your insurance company. Moreover, this is not a complete list as your insurance company may designate other services and supplies as non-covered without providing notice to Reboot Center.

- Nutritional Supplements
- Functional Blood Assessment
- FBA 24-hr Incubation
- Intramuscular Injections
- Intravenous Injections
- Neural Therapy
- Far Infrared Sauna
- BioImpedance Analysis
- Laser Therapy
- Scenar Therapy
- Local Infrared Therapy
- Liquid Mineral Testing
- Allergy Skin Scratch Testing

I, _____ agree to pay for any services and/or supplies that my dependent's insurance company deems not medically necessary or investigational and not to seek reimbursement for these supplies/services from my dependent's insurance.

Signature: _____ Today's date: _____