**Hands of Light Chiropractic Care Maureen C. Boylan DC**

5202 Beechmont Avenue, Cincinnati OH 45230 Phone: (513)231-2892

**Office Policies**

The goal of this office is to enable patients to gain control of their health in a calm and healthy environment. To attain this I believe communication is the key. Please read and sign below and if you have any questions please feel free to ask.

**Fees:**

New Patient Examination and History and treatment (2 hours) - **$175-190 (more if very complex)**

Established Patient Update/Ouch Examination Visit (60 minutes) - **$90 (more if very complex)**

Regular Chiropractic Office Visit/Treatment (30 minutes) - **$65**

Extra time for complex treatment/multiple areas of treatment (30 minutes) - **$30**

Energy Healing Session, current patient (30 minutes) $65

Energy Healing Session, New Patient to office (60 minutes) $130

Custom orthotics - **$290** per pair

**Late Cancel/No Show fee - $65**

**Billing Fee - $20 per visit, each monthly statement** for fees not paid at time of service

**Using Your Insurance:**

**Payment is due for all care at the time of service. Dr. Boylan is an Out of Network Provider and does not accept assignment on insurance**. After payment is received, as a courtesy, this office will send electronic insurance claims instructing the insurance company to reimburse the patient according to their out of network benefits.

\_\_\_\_\_\_\_ I have contacted my insurance company and completed the Insurance Verification form.

\_\_\_\_\_\_\_ I do not wish for insurance to be filed.

**Missed Appointments:**

There is a $60 fee charged for no-shows as well as appointment cancellations without 24 hours’ notice. This fee is due from the patient and will not be filed to insurance.

**Communications/Patient Privacy:**

In the event that we would need to communicate regarding your healthcare information, to whom may we do so?

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_

No one is to be contacted: \_\_\_\_

May we leave messages regarding your personal healthcare information on your answering device i.e. home answering machines or voicemail? Yes [ ] No [ ]

**Acknowledgement**

I have read and fully understand the above statements.

I understand that the notice of privacy practices (HIPAA) will be made available to me for review, on my request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of **Patient** (or Parent/Guardian)

**Print** **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**