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 - $150

Established Patient Update/Ouch Examination Visit (45 minutes) - $75

Regular Chiropractic Office Visit/Treatment (30 minutes) - $50

Extra time for complex treatment/multiple areas of treatment (15 minutes) - $25

Custom Orthotics - $290 per pair

Late Cancel/No Show fee - $50

Billing Fee - $10

**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 $50 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 voicemails? 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.

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**Signature of Patient or Parent/Guardian**

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