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Healing Hands Wellness LLC
631 Cleveland Ave South
Saint Paul, MN 55116

Patient-Doctor Financial Policy, Client Agreements and Expectations for 2021

Patient Expectations:

1- Be received in a prompt, friendly, confidential and professional manner at all times
2-Be treated with state-of-the art orthopedic spinal/extremity treatment, nutrition and acupuncture care
3-Be assured in the faith and knowledge that staff and doctors at this clinic are your health partners for life.

Arrival:

Verbally check in at the front desk, present ID, take off jewelry that may interfere with your treatment, place cell phone on vibrate and as recommended schedule all future visits in advance.

Cash Fee Schedule

Healing Hands Wellness LLC offers discounts on most medically necessary clinical services. All cash or time of services patients [chiropractic care, acupuncture treatment or therapeutic sessions] will be offered to 60% off itemized professional services as noted below.

Accepted insurance clients who have unpaid deductibles are responsible for comparable out-of-pocket amounts. Co-payment, as well payments for non-contracted services you are informed of and agreed to as medically necessary are due at time of service.

$75.00 [normally $185.00) [99203] for chiropractic, acupuncture or nutritional examination/consultation
$55.00 (normally $140.00) [99213] for re-examination/consultation
$45.00 (normally $85.00) [98941] for 3-4 region chiropractic manipulative treatment
$45.00 (normally $85.00) [98941] for ongoing acupuncture treatments
Dot medical examination: discounted at $45.00
$35.00 normally ($65.00) [98943] for extremity [knee, ankle, shoulder, elbow or wrist or Activator cranial chiropractic manipulative treatment

$25.00 (normally $50.00) [97010] for modality [hot/cold, EMS, US, mechanical traction or rapid pian relief treatment

$25.00 ($50.00) [97140] for procedure [manual traction, manual therapy]

$35.00 (normally $65.00) [97110] per service [exercise therapy/instruction]

Plan Selected: ……..

I agree to this plan and understand my payment responsibility: ……..

Patient's Printed Name and Signature: …… ……Date……..

Doctor's Printed Name and Signature: ……. ……Date……..