PARK
CLINIC

OFFICE AND FINANCIAL POLICIES

INSURANCE: We participate in most insurance plans, including Medicare. Knowledge of your insurance benefits and eligibility is patient responsibility. Please contact your insurance company to confirm that the Clinic and provider is currently under contract with your plan. If required by your plan, please ensure your primary care provider is identified on your insurance card. If uninsured or not insured by a plan we are contracted with, you will be responsible for the payment of your services.

PROOF OF INSURANCE: Patients must complete our patient information form before seeing the providers. We must obtain a copy of your driver's license and valid insurance cards. You should notify us as soon as possible if your insurance changes. If you fail to provide us with accurate and complete insurance information, you will be responsible for the account balance.

CO-PAYMENTS: Co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from the patient can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.

NON-COVERED SERVICES: Please be aware that some or all service provided may be, as described by your insurance company, non-covered or not considered reasonable or necessary by policy standards. Payment for all services not covered by insurance will be your responsibility.

NON-PAYMENT: Please be aware that if a past due balance remains unpaid, we may refer your account to a collection agency.

MISSED APPOINTMENTS: We request a 24-hour advance notice if you must cancel or reschedule your appointment. For your convenience, we offer appointment reminders prior to your appointment which will allow you to cancel or reschedule at that time. Three (3) or more no-shows or same day cancellations within a year may result in dismissal from your provider.

I have read, understand and agree to the above office and financial policies.

Patient Name (printed)	Date of Birth
Patient / Guarantor Signature	Date