



PRIMARY CARE CLINIC

PAYMENT AGREEMENT

I, _____, agree to pay for services and/or supplies rendered to _____, on this date, _____, at the rate indicated on the Primary Care Fee Schedule. Failure to comply with this agreement may jeopardize my ability to continue receiving services at the Platte County Health Department -- Primary Care Clinic.

No Show Policy

Due to the limited number of appointment slots available per week for Platte County Health Department Primary Care Clinic, a policy of "Failure to Show" has been implemented for those patients who repeatedly do not keep their scheduled appointments.

Patients who schedule and then do not keep 3 appointments will not be allowed to schedule again with the primary care clinic. This also includes patients who call within one hour prior to their scheduled appointment without a legitimate excuse, because by then it is too late to give the appointment to another patient.

I have read and understand the above policies and agree to give at least 24 hours notice in the event that I cannot make my scheduled appointment.

Signature of Responsible Party

Date

Witness

Date