DR. JULIA PARKE N.D.
ADMINISTRATIVE and SERVICE POLICIES

Welcome! I look forward to working with you on your healthcare needs. This document contains important policy information that pertains specifically to you. Please read over the entire document, if you have any questions please feel free to ask Dr. Parke for clarification.

Appointments

An appointment is considered to be an agreement between you and the doctor. If for any reason you need to miss an appointment and do not cancel ahead of time, I would be unable to provide service to another patient during your scheduled time. I am responsible to provide promised services, or to inform you otherwise; you are responsible for keeping the appointment or giving a 24-business hours notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice, you may be charged an **$75.00 cancellation fee**.

_____ please initial

Payment

Payment is required in full at the time services are rendered. An invoice will typically be sent out by email with in the week of your appointment through Square-up services. Check, Cash, Visa or Mastercard payments are all acceptable and there is even an option for direct deposit from your bank. There will be a $25.00 fee for all returned checks.

_____ please initial

Insurance

Dr. Parke ND. is not a recognized provider for any insurance companies in California, nor Oregon. Billing documentation will not be submitted to insurance companies.

_____ please initial

Emergencies

If you have a true medical emergency or serious medical concern you are to call 911 immediately. If you have an urgent medical concern please call the doctor's provided phone number. If it is after regular business hours, 9-5 PST, M-F, please leave a message for Dr. Parke at (541-513-1978) and I will return you call the next business day. If you feel you can not wait until the next business day it is your responsibility to seek the appropriate medical care.

_____ please initial

I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below.

_____ Date: _____
Patient Signature

_____
Printed Name