Lifespan Family Healthcare
80 River Road
Newcastle, ME 04553
(207) 563-3366
Fax (207) 563-3393

FINANCIAL POLICY

As a courtesy to our patients we file most insurance. Please be aware that some or perhaps all of the services rendered may or may not be covered. If your insurance company denies payment, you will be billed and payment in full is due upon receipt.

We cannot file your insurance unless you have your card with you. Your insurance must be current and verifiable at the time of treatment. Payment assignment must be made to this office. If you wish to have the check sent to you, payment in full is due at the time of service. Co-pays and payment for non-covered items are due at the time of treatment. **We charge $35 for "No-Show" appointments, to be paid prior to or on your next appointment**. We accept cash, checks and major credit cards. Should it be necessary to utilize outside collection means for past due account, you are responsible for all cost, including attorney, court, and collection fees. We will not carry balances for more than 2 years. A minimum $35.00 fee will be assessed on all returned checks.

I have read and understand the Financial Policies of Lifespan Family Healthcare, LLC and have completed this form to the best of my ability and will not hold Lifespan Family Healthcare, LLC responsible for my errors or omissions.

Signature_____Date_____

IF YOU HAVE MEDICARE OR MAINECARE PLEASE READ:

MEDICARE/MEDICAID AUTHORIZATION

I requested that payment of Authorized Medicare Benefits be made to Lifespan Family Healthcare, LLC for any services furnished to me by Michael H. Clark, MD. I authorize any holder of information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents information needed to determine benefits. If I have other insurance, my signature authorizes releases of information to that insurer or agency. In Medicare/Medicaid assigned cases, the physician agrees to accept the determination of the carrier as payment in full and the patient is responsible for deductibles, coinsurance, and non-covered services.

Beneficiary
Signature_____Date_____