JONESBORO CHURCH HEALTH CENTER

Form Update: March 2026

500 Kitchen
Jonesboro AR 72401
870-972-4777
www.jonesborochurchhealth.org

SERVICE AGREEMENT

The Jonesboro Church Health Center (JCHC) is a nonprofit clinic for the purpose of treating patients without insurance. Patients are seen and evaluated by a nurse practitioner; however, a physician is available for consultation if necessary.

JCHC is strictly an outpatient clinic. Patients are seen by appointment only.

Hours of operation are Monday to Thursday from 8:00 am – 3:45 pm.

There is no after hour coverage nor do the providers admit patients to the hospital.

Appointment cancellations should be made 24-hours prior to the scheduled appointment or as soon as possible.

If a referral to an outside physician/clinic is necessary for evaluation and/or tests, the patient will be responsible for payment.

The office visit fee is $25.00. Lab services are available through the clinic, and the patient will be responsible for all lab charges at the time of the visit. Income status is required based upon the Housing and Urban Development Income Limits for the purposes of tracking poverty levels and applying for funding.

This document authorizes the clinic to conduct the Department of Human Services, Social Security Administration, private insurance companies, pharmacies or physician's offices to verify any information given to this clinic by you regarding insurance, Medicaid or Medicare coverage.

JCHC does not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of the activities or operations. These activities include, but are not limited to, hiring and firing of staff, selection of volunteers and vendors, and provision of services. We are committed to providing an inclusive and welcoming environment for all members of our staff, clients, volunteers, subcontractors, vendors, and patients. We do reserve the right to refuse treatment.

Patient Signature:_____ Date: _____

Witness: _____Date: _____