Renee Family Health and Psychiatric Nurse Practitioner Office PLLC
Virtual Office
Reading PA 19601
1(800) 235-9770

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0. Financial Responsibility (Self Pay)

I am the::

Patient name:

- [ ] I the undersigned hereby agree to be personally responsible for the costs of all healthcare services provided to me by Dr. Renee Denobrega and have declined using Health Insurance for these services.
- [ ] CREDIT/DEBIT CARD I authorize Renee Family Health & Psychiatric Nurse Practitioner Office to charge my credit/debit/health account card for professional services within15 minutes before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Dr. Renee Denobrega will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge.

Credit/Debit Card Authorization

(Card holder) Name on card if different than patient:

Card Type:

Card number:

CVV / CVV2:

Expiration Date:

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Date:

Patient/Authorized Legal Representative sign below: