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

0. Insurance Information & Financial Responsibility (for Insured patients)

I am the::

Note: You will be charged a $30 fee approximately 15 minutes before your scheduled appointment time for your first appointment. Please contact your insurer before scheduling an appointment to verify that the insurer will cover or reimburse this cost to you and for future behavioral health visits with this out of network provider. You will not be charged additional out of pocket cost for your first visit if your insurer denies coverage.

Patient's name:

☐ I agree to be personally responsible for the costs of all healthcare services provided to the patient above by Dr. Renee Denobrega in the event the healthcare services rendered are not covered or paid for by their Health Insurance Plan. I also understand that a referral from the patient's primary care physician and or pre-certification from their insurance carrier may be required for the services rendered by Dr. Renee Denobrega. I understand that without the appropriate referral, and /or precertification, I will be responsible for payment of the total charges for all denied services. I understand that it is my full responsibility to contact the patient's insurance carrier in an effort to ensure full compliance of payments and explanation of benefits on behalf of the patient. Dr. Renee Denobrega is not responsible for verification of the patient's benefits and eligibility of services.

Insurance Company:

Primary Insurance Co. (if not listed above):

Was insurance Co. Contacted to verify coverage?:

called:

Group #:

Subscriber:

Subscriber SS#:

Subscriber Employer:

Subscriber Birth Date:

Was your insurance company notified of this visit:

called:

Secondary Insurance:

☐ I hereby authorize payments directly to the provider of service(s) for the medical benefits, if any, payable to the patient under the terms of the private, group, Medicdare, and Medigap policy. I hereby authorize the provider of service to release any medical information necessary to process the patient's claim. I hereby authorize copies of this form to be valid as original.

☐ CREDIT/DEBIT CARD I authorize Renee Family Health & Psychiatric Nurse Practitioner Office to charge this credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Dr. Renee Denobrega will charge this 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. I authorize this card to be used for co-pays and fee's incurred while still a patient with Renee Family Health & Psychiatric Nurse Practitioner Office.

Credit/Debit Card Authorization

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

Card Type:

Card number:

CVV / CVV2:

Expiration Date:

☐ I verify that the 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.

Patient or Authorized Representative's Initials:

Card holder Initials (If different from the above):

Date:

Patient or Authorized Representative Sign here: