Maria I. Betancourt, M.D., PLLC

Maria I. Betancourt M.D.
Rahela Sachedina N.P.-C

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide to you. Occasionally, gynecological services provided will not be covered by your health plan or there is a deductible, co-payment, or co-insurance that you or we are not aware of at the time of your visit.

Our office will make every effort to obtain full payment from the insurance carrier, we are by law, required to collect any amount listed on the Explanation of Benefits (usually received by you at the time the claim was processed) as "patient responsibility".

In order for our office to run smoothly and continue to offer you high quality care, we respectfully request that you sign below to authorize Dr. Maria I. Betancourt to keep your signature on file and charge your credit card for the balance of charges not paid or covered by insurance.

You will receive a call prior to our charging in excess of $250.00

Thank you for your understanding, and for allowing us to provide you with our services.

Maria I. Betancourt, M.D. PLLC

Patient Name: ______________________________________ **DOB:** _______________

Name on Credit Card: _____________________________________

Credit Card Number: ____________________________ **Expiration Date:** ____________

Card type: (please circle one)
Visa Master Card American Express Discover

Name on Flex Card: _______________________________________

Flex Card Number: _______________________________ **Expiration Date:** ____________

Card type: (please circle one)
Visa Master Card American Express Discover

Signature: ____ **Date:**_______________

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