**Maria I. Betancourt MD, 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. We have agreed with your insurance company to accept a particular rate for these services. Our office will make every effort to obtain full payment from the insurance company, 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 paid) as "patient responsibility". This includes co-payments, in-network deductibles and co-insurances and any fees for uncovered services.

So as to avoid expensive billing costs and the need to arrange for payment, it is our policy to obtain your credit card number and authorization to process a claim for your patient responsibility. We would only process this charge in the absence of coverage by your health benefit plan for such charges as noted above, and totaling under $100.00. You will be notified by telephone prior to processing if the charges exceed $100.00.

Please be assured that your credit card information will be held securely, and that providing us this information will not compromise you ability to dispute a charge, or question you insurance company's determination of payment.

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

Patient Name: _____

Name on Credit Card: _____

Card Type: □ Visa □ Master Card □ American Express □ Discover

Card Number: _____

Expiration Date: _____ Authorization Code: _____

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