Jaana Rehnstrom MD
103 Fifth Ave. 3rd fl.
New York, N.Y.10003

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs. However we continue to experience problems with no-shows, while other patients wait weeks for appointments. In addition, we are experiencing record numbers of denied insurance claims due to inaccurate or invalid information. As a result, when you booked your appointment, you were asked for credit card information by our front desk. In the event that you cannot keep your appointment and do not cancel it at least ONE FULL BUSINESS DAY in advance, we will charge your credit card $50.00 for the missed appointment. (We will, on a case by case basis, waive this fee if you can verify an emergency situation which kept you from coming to your appointment.)

Furthermore, as you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of coverage that our health plan provides. Your responsibility for co-payments, deductibles, and co-insurance is a decision made by your employer and your health plan. Our office will be pleased to work with your health insurance plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Bear in mind that YOU are ultimately responsible for payment of the medical services provided to you. Therefore, *should your health plan not honor the claim we submit for the services provided to you,* we will be obliged to charge your credit card for the services rendered by our office.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health insurance plan (including, but not limited to, co-payments, co-insurance, deductibles, and/or uncovered services) in an amount not to exceed $ 500. *You will be contacted by mail or phone prior to issuing charges to your credit card.*

Patient Name:____

Name on Credit Card:____

Card Type: (please circle one) Visa Mastercard

Card Number:____Exp ___/____

Signature:_________________________________ Today’s Date:______________