ANDREA CRONIN

PSYCHIATRIC NURSE PRACTITIONER

Payment Authorization and Cancellation Policy

Andrea Cronin Family Health PC
200 Katonah Ave Suite 14 B
Katonah NY 10536
(914) 301-7400

I hereby authorize Andrea Cronin Family Health PC to apply for benefits on my behalf, if applicable, for the services rendered so that payment may be processed at the time of service by charge on the credit card listed below. By signing this authorization, you are confirming you are an authorized user on this card and have the right to make charges on the card listed below.

** Please note cancellation policy: Andrea Cronin Family Health PC reserves the right to charge a $50.00 cancellation fee for any appointment cancellations made with less than 48 business hour notice.
You will be notified by mail when a cancellation fee is charged to the credit card listed below.

Card Holder Name: _____DOB: _____

Card Number: _____Type: _____

Expiration date: _____ CVV: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

By signing below, I authorize Andrea Cronin Family Health PC to charge this credit card for the total amount of fees for services rendered and for applicable cancellation fees as above. I am responsible for maintaining updated and accurate billing information and in the event there is a problem with this credit card payment, I am responsible for paying the fees to Andrea Cronin Family Health PC directly.

Printed Name: _____

Signature: _____ Date: _____

02/2020