DONOVAN

Reprinting of Invoices

PART 1. PATIENT CONTACT INFORMATION

PATIENT FIRST NAME: _____ PATIENT LAST NAME: _____

DATE OF BIRTH: (DAY/MONTH/YEAR) : _____

PATIENT ADDRESS: _____

_____

PATIENT PHONE NUMBER: _____ EMAIL _____

PART 2: Which invoices do you require reprinting?

☐ All invoices for the following time period FROM _____ TO _____

☐ A specific invoice relating to my visit on the following date _____

PART 3: How are we to send your reprinted invoices to you?

☐ Email the invoices to me ☐ Mail the invoices to me

PART 4. VERIFICATION OF REQUEST

I have lost or misplaced my invoice pertaining to my previous visits. I understand that there are no charges for reprinting of my first five lost or misplaced invoices. I understand that there is a fee of $ 10 +tax for any additional invoices beyond the first five. I understand that invoices will be sent to me by mail or email within 3 weeks of the date signed below

_____ _____

DATE (DAY/MONTH/YEAR) SIGNATURE

PART 5: CREDIT CARD BILLING INFORMATION

AMOUNT TO CHARGE : _____

NAME ON CARD: _____

CREDIT CARD NUMBER _____

EXPIRY DATE: _____ 3 DIGIT CVV CODE _____