# Financial Policy

All payments are due prior to being seen. It is the policy of **Joanne Martelli, PMHNP-BC** to obtain and maintain on record a valid Visa or MasterCard and authorized signature. This will remain in your confidential file as a guarantee of payment and allows us to avoid having to take collection actions against any client. **No charge will be billed to this account unless the owner fails to reconcile debts to Joanne Martelli, PMHNP-BC.** If you do not wish to complete this form you may seek services elsewhere and I will assist you with a referral.

If you elect to use your insurance benefits to pay for services, you will still need to complete this entire form, as having benefits is NOT a guarantee of payment. If I have a contract with your managed care insurance company, the billing procedures of that company will be followed. My billing specialist will make every attempt to collect from your insurance company including telephone calls to said company if necessary. However, in the event that any insurance company obligated by contractual agreement to make payments on your behalf for services provided, refuses to make such payments, **you will become personally responsible for the amount due.**

The signed credit card collection policy is for services at the office of **Joanne Martelli, PMHNP-BC**. By signing below, you hereby authorize me to collect any outstanding amount, including co-pays, on your credit card listed below. **This includes missed appointment fees, which will be charged on the day of the missed/cancelled appointment when 24 hours business notice is not given for medication appts and 72 hours business notice for evaluations.**

**There is a 3.5% plus 15 cent CASH fee for manual credit card transactions. This fee can not be added to the credit card charge and must be paid by cash or check.**

**Client's Name: _____**

**Please circle one: Visa or MasterCard**

**Card Member Name: _____**

**Card Number: _____CVV_____**

**Expiration Date: _____ Zip Code: _____**

**Card Member Signature: _____**

**Date: _____**

**Provider Signature: _____**