Joanne Martelli, PMHNP-BC
Psychiatric Nurse Practitioner Board Certified
Cooper Crossing 1820 E. Ray Rd; Suite 206A
Chandler, Arizona 85225
Tel: 623: 692-9933 Fax: 480:912-3393

Today's Date_____

Name _____ Social Security Number_____

Address _____ Date of Birth _____ Age_____

City _____ State _____ Zip _____ Sex: M_____ F_____

Home Telephone _____ Work Telephone _____

Employer (School attending if minor) _____

Marital Status: Single _____ Married _____ Other (specify)_____

Referred to this office by _____

In case of emergency, please notify: Name_____

Telephone (_____) _____ Relationship
_____

Insurance Company _____ ID# _____

Patient's relationship to policy holder (primary insured):

Self _____ Spouse _____ Child _____ Other (specify) _____

BELOW PORTION MUST BE COMPLETED
The following section is for information about the policy holder (primary insured) If differed from the above:

Name _____ Social Security Number _____

Address _____ Date of Birth _____ Age_____

City _____ State _____ Zip _____ Sex: Male___ Female __

Home Telephone (_____) _____ Work Telephone (_____) _____

Employer _____

Consent for Treatment

I, _____, grant Joanne Martelli, NP permission to provide psychiatric services to me and/or to _____, a minor. These services may include, but are not limited to; individual psychiatric evaluation and medication management. I understand that information given to Joanne Martelli, NP will not be shared with any outside source without my written consent, except where required by law.

I understand that Joanne Martelli, NP may determine that additional or specialized evaluation or treatment is clinically necessary and may make appropriate referrals. However, I am still free to choose my own treatment or to choose to seek no further treatment.

Signed _____ Date _____
Patient or Parent/Guardian

Authorization to file insurance claims

I hereby authorize Joanne Martelli, NP to release any medical or other information necessary to process medical insurance claims on my behalf. I also authorize the payment of any medical insurance benefits due to me for these services directly to Joanne Martelli, NP.

Signed _____ Date _____

Agreement to pay for services rendered

I acknowledge that I am responsible for the fees for all services rendered to me or to members of my family. I understand that the fees are due and payable at the time the services are rendered. If it is expected that the fees will be paid in part by my insurance plan, I have signed the 'Authorization to File' above and will pay my portion of the fees (the deductible, or the 'copay' amount) at the time of service; if my insurance plan declines coverage for any reason, I acknowledge that I am responsible for the remainder of the fees. If an insurance plan is not involved, I will pay the full fee due at the time the services are rendered.

Signed _____ Date _____
Patient or Parent/Guardian