

Joanne Martelli, PMHNP-BC
Psychiatric Nurse Practitioner Board Certified
Cooper Crossing 1820 E. Ray Rd; Suite 206A
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Fee Policy

Fees for all services are due and payable at the time the services are rendered. Please be aware that fees for other than regular psychiatric services are generally not covered by insurance plans and will be billed directly to you.

Fees for Psychiatric Services

Initial Evaluation: \$285.00-Cash Clients (Non-Insurance or Unmet Deductibles)

Medication management/Follow up: \$150.00 -Cash Clients (Non-Insurance or Unmet Deductibles)

Initial to agree and understand with above amounts _____

Fees for other Services

Copy of Records: \$15.00 +

Out of Office Consultation: \$300.00

Report, Disability Forms, FMLA, School Forms or Letter Writing: \$150.00 +

Cell Phone Calls (depending on circumstances and urgency): \$50.00+

If we have to re-write your script for any reason (not including refills): \$25.00 per script

Initial to agree and understand with above amounts _____

Appointment Cancellation

A minimum of 24 business hours' notice is required to cancel a medication appointment and 72 business hours for an evaluation. If you cancel an appointment with less than 24/72 business hours notice or fail to arrive for an appointment, you will be charged a fee of \$60.00 for medication appointments and \$285 for eval appts. Since insurance plans do not cover missed appointments, this fee will be billed directly to you and it must be paid the day of the missed or canceled appt.

Also, if for ANY reason you have an outstanding balance with us it must be paid in full before any appointments are made or refills on scripts will be given.

Initial to agree and understand with above amounts and statements _____

Insurance

You are responsible for all fees incurred regardless of insurance coverage. If these services are covered by your insurance plan and you have signed the 'Authorization to File' your claim for benefits will be filed for you. You must pay the deductible required by your insurance plan and the portion of fees for each session that are not covered (your co-pay). If these services are not covered by your insurance plan or if you have no insurance coverage, you must pay the full fee.

In ALL cases, there will be a \$20.00 surcharge for checks that are returned due to non-sufficient funds. (Any check returned to us with non payment)

Initial to agree and understand with above amounts and statements _____

Signature

Date

Witness

Date

I received/waived receipt of and understand the HIPAA information
