Marianne Tomlinson Therapy, LLC
1605 W. Wilson St., Suite 111
Batavia, IL 60510
630-337-6571

Financial Policy

Thank you for choosing Marianne Tomlinson Therapy, LLC. We are committed to providing you with the best possible care. Your understanding of our financial policy is important in forming a successful alliance between us.

Payment of all fees and copayments is expected at the time services are rendered unless other arrangements have been made. Should you elect to pay out-of-pocket for your sessions, you must pay for each session as they occur. You can pay by cash, check, or we can charge your credit card (Visa, MC, American Express, or Discover). **We do require that you provide us with a credit card number to keep on file.** This prevents the need for collection agencies and will help protect your credit score. We are always willing to offer extended monthly payments if necessary (credit cards only). We will reach an agreed upon extended payment per month until your balance is paid off.

Should you choose to use your insurance benefits, we will assist you in processing insurance claims by billing your insurance directly as appropriate for reimbursement. It is important that you understand that our relationship is with you and not with your insurance provider. Any assistance in processing insurance claims is provided as a courtesy to you. Payment of all unpaid amounts, co-payments, and deductibles are your responsibility.

A forty-five ($45) fee is charged for returned checks. If financial problems that impact your ability to pay your fee arise, please discuss them with us. If your account becomes delinquent, you will be responsible to pay the costs necessary to collect your portion of the fee due. This includes court and attorney fees and an interest rate equal to the statutory amount at the time of the debt. You will receive appropriate notice of efforts to obtain this debt. A failure to comply and respond to such request within the statutory period for an answer will result in a confessed judgment against you for the amount of the debt and any fees required to collect the debt.

If you need to cancel your appointment, please do so with a 24-hour or more notice. **Any appointment cancelled with less than 24-hour notice will be charged a $65 out of pocket fee as insurance will not cover missed sessions.** If there are extenuating circumstances, please let us know so that we can discuss the outcome.

Credit Card Information:

This form will be kept on file and remain in effect until the expiration of the credit card amount. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

Do you authorize Marianne Tomlinson Therapy, LLC to charge recurring charges for fees, copayments and deductibles to your credit card on a monthly basis?

Please place your initials next to the desired response: YES _________ NO _________

_____ Visa _____ Master Card _____Discover _____ American Express

Card Number ____

Card Expiration ____

CVS Code (3 or 4 digit number on back of card) ________________________________

Authorized Signature ____

Date _____________________________

I have read and understand the above financial policy. I consent to the above payment terms for my treatment at Marianne Tomlinson Therapy, LLC and I authorize Marianne Tomlinson Therapy, LLC to keep my credit card number on file and authorize charges to my credit card for unpaid balances over 30 days past due. I have been given the opportunity to have my questions answered regarding this financial policy.

PRINT NAME OF CLIENT OR CLIENT'S REPRESENTATIVE **DATE**

SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE **RELATIONSHIP TO CLIENT**