Dr. Debra Levidow
7789 E. Tailspin Lane
Scottsdale, AZ 85255
602-908-3414

COLLECTIONS POLICY

It is the policy of this office to obtain and maintain on record a valid Amex, Visa or MasterCard and authorizing signature. This will remain in your confidential file as a guarantee of payment and allows me to avoid having to take collections actions against a client. No charge will be billed to this account unless the owner of the card fails to reconcile debts for services rendered, regarding fees and client responsibilities, or unless client chooses him/herself to use this card number to pay for services at the time of session, including scheduled phone sessions, clinical phone conversations or professional consultations between sessions. If agree to latter statement, please initial here_____.

Please be reminded that clients are responsible for payment at the time of session, and they are responsible for any fees or any charges associated with no shows or late cancellations as per policy on the day of occurrence. If agreed upon, fees owed outside of in-person sessions can be charged to credit card on file.

If you have an outstanding balance, I will make three attempts to collect payment. You are responsible for making sure your record shows an updated credit card and mailing address at all times and also for signing for any certified mail sent from this office. Failure to keep updated information or refusing certified mail notifying you of attempts to collect outstanding balances does not exempt you from this collection policy.

If your account is not cleared within 30 days of the last collection attempt, you hereby authorize me to collect any and all outstanding amounts on the credit card listed below.

You are also authorizing the release of billing statements showing the validity of the charge(s) to the credit card company should that become necessary. In the event charges are billed to this account, you will be sent a copy of the credit card charge and reconciled bill within 7-10 business days.

This signed credit card collections policy is for the use only for services rendered by Dr. Debra Levidow and/or for fees associated with client's late cancellation or no show for appointments. Your initials below indicate you have read and understand this policy and it has been discussed. Initial above if approve.

Client _____ Psychologist_____

Clients name_____

VISA MASTERCARD AMEX (Please circle one)

Card Member Name & Signature_____
Card Number: _____
Expiration Date:_____ Security code on back: _____
Billing Address: _____
_____