Legal Name _____

Preferred Name _____

Today's Date _____

Initial Adolescent Patient Intake Form

Education & Interests

Where do you attend high school? _____

What grade are you in? _____

Do you have an individualized education plan or special education? Yes No

Have you ever been suspended from school? Yes No

Were you made to repeat a year? Yes No

Do you participate in extracurricular activities, like clubs or sports? Yes No

If so, which ones?

_____

Living Situation

What city were you born in? _____

What city/town do you live in currently? _____

What type of home do you live in (e.g. house, mobile home?) _____

Who shares the home with you? _____

Are there guns in the home? Yes No

Are there other weapons in the home? Yes No

Family

Has anyone in your family abused alcohol or drugs? Yes No

Has anyone in your family attempted or completed suicide? Yes No

Has anyone in your family been diagnosed with a psychiatric illness? Yes No

Has anyone in your family been hospitalized for a nervous breakdown? Yes No

Has anyone in your family died suddenly of a heart problem before age 50? Yes No

Lifestyle

Have you ever regularly used nicotine or tobacco? Yes No

What type do/did you use (e.g. vape, cigar, snuff)? _____

About what year did you start? _____

What year did you quit? _____

How many days a week do you get 30 min of exercise? 0 1 2 3 4 5 6 7

Do you follow a diet or have dietary restrictions? Yes No

Do you consume caffeine (e.g. energy drinks, coffee) regularly? Yes No

Do you drink alcohol? Yes No

Do you smoke or otherwise use marijuana? Yes No

Have you ever injected drugs? Yes No

Do you use other drugs? Yes No

Psychiatric History

Have you been evaluated by a psychiatrist before? Yes No

If so, please list psychiatric diagnoses:

_____

Have you ever been hospitalized for psychiatric reasons? Yes No

If so, please list the name of the hospital and approximate date:

_____

Have you ever seen an outpatient psychiatrist or therapist? Yes No

If so, please list his/her name and approximate dates under his/care:

_____

Have you ever attempted to take your own life? Yes No

Medical History

Please list any medical diagnoses:

_____

_____

Please list any allergies or bad reactions to medications:

_____

Have you ever had a head injury or seizure? Yes No

Please list current medications:

_____

_____

_____

Please list any surgeries:

_____

Are you currently pregnant or planning to become pregnant? Yes No

Do you have a pediatrician? Yes No

If yes, what is his or her name? _____

Other

What is the longest period you have gone without sleep? _____ days

Do you have trouble with concentration or focus? Yes No

Are you unhappy with your weight or your body? Yes No

Have you ever abused laxatives or exercised excessively to lose weight? Yes No

Have you ever induced vomiting after eating? Yes No

Have you ever had your life threatened? Yes No

Have you ever seen someone else's life threatened? Yes No

Have you experienced trauma, abuse, or neglect? Yes No

Do you have nightmares or flashbacks related to the above? Yes No

Do you consider yourself either religious or spiritual? Yes No

Have you ever had a panic attack? Yes No

Have you ever engaged in self-harm to relieve anxiety? Yes No

Do you have rituals or beliefs that others might find unusual? Yes No

Do you hear voices or sounds that others cannot hear? Yes No

Do you see things that others cannot see? Yes No

Do you have special powers or abilities? Yes No

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Genesis Behavioral Health Services
433 Metairie Rd, Suite 520, Metairie, LA 70005

AGENCY INFORMATION & POLICIES

Appointment Policies

- A minimum notice of 48 hours is required to cancel or reschedule your appointment without being charged a cancellation fee.
- Late arrival to your appointment will reduce session time.
- Charts close after 12 months of inactivity. If you have not been seen within the last 12-months, a new psychiatric evaluation will be required.
- Managing appointments is your responsibility. Agency does not make reminder calls.

Appointment Information

Psychiatric evaluations: 1-hour, In-person, $200

Psychiatric follow-ups: 30-minutes, $150

The following documents must be completed prior to initial visits: 1) New Patient Packet, 2) Consent Forms, 3) Copy of Insurance Card (front and back), 4) Copy of Driver's License.

Medications

- 48-hour notice required for prescription refills

Office Contact

Website: https://genesisholisticbr.com/
Hours: 8a-5p
For scheduling, contact our front desk at:
P: (985) 624-2942

Emergency

If there is an emergency and you are in crisis and unable to wait for a return call, please call 911, go to your nearest emergency room, or call/text the 988 Suicide and Crisis Lifeline.

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PATIENT INFORMATION SHEET

PATIENT INFORMATION

Patient's Name: _____ Pronouns: _____
Last First

Home Address: _____
City State ZIP

Date of Birth: ____/____/_____ Age: _____ Gender: _____

Email: _____ Phone Number: (_____)_____-_____

Marital Status: Married Single

PHARMACY

Name: _____ Phone Number: (_____)_____-_____

Location: _____
City State ZIP

INSURANCE

We are required to submit your insurance information when obtaining prior authorization for prescriptions. Please attach a copy of the insurance card, front and back, and driver's license.

Insurance Company: _____ Phone Number: (_____)_____-_____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder DOB: ____/____/_____
Last First

Employer of Policy Holder: _____

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SPOUSE/PARTNER

Spouse/Partner Name: _____
Last First

Email: _____ Phone Number: (_____)_____-_____

PARENT/GUARDIAN

Parent/Guardian Name: _____
Last First

Home Address: _____
City State ZIP

Email: _____ Preferred Phone Number: (_____)_____-_____

PARENT/GUARDIAN

Parent/Guardian Name: _____
Last First

Home Address: _____
City State ZIP

Email: _____ Preferred Phone Number: (_____)_____-_____

EMERGENCY CONTACT

Contact Name: _____
Last First

Relation: _____ Phone Number: (_____)_____-_____

Home Address: _____
City State ZIP

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REFERRAL SOURCES

Name/Agency: _____ Phone Number: (_____)_____-_____

NOTICE OF PRIVACY PRACTICES (BRIEF VERSION)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Our commitment to your privacy Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached. full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent We will use the information we collect about you mainly to provide you with **treatment** to arrange **payment** for our services. and for some other business activities that are called. in the law. **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways If you do not consent and sign this form, we cannot treat you If we want to use or send. share, or release your information for other purposes. we will discuss this with you and ask you to sign an authorization form to allow this

Disclosing your health information without your consent There are some times when the laws require us to use or share your information For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat
2. When we are required to do so by lawsuits and other legal or court proceedings
3. If a law enforcement official requires us to do so
4. For workers compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices

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Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2 You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can get a copy of these records. but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes

5. You have the right to a copy of this notice. If we change this notice. we will post the new version in our waiting area. and you can always get a copy of it from the privacy officer

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U S Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state. and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise If you have any questions regarding this notice or our health information privacy policies. Please contact our privacy office: who is Hannah Hopkins and can be reached by phone at 225-317-9419 or by email at hannah@genesisholisticbr.com

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

STATEMENT OF CONFIDENTIALITY

By participation in a program and/or by your presence at this facility, you will be privileged to certain confidential information regarding clients involved in the program.

Confidentiality, a right entitled to each client, begins at admission to a program or upon the making of a request for admission. Any and all information imparted to you during the time that you are at this facility and/or your knowledge of any person or persons here is strictly confidential. The privacy of our clients and their rights to be treated with total confidentiality is protected by law. This

disclosure of any information pertaining to a client and their treatment may be in direct violation of Federal Regulations and may be punishable by fine or imprisonment or both. By signing this statement of confidentiality, you are acknowledging that you have read, understand and agree to the terms stated above and that all information and the presence of others at this facility will remain confidential.

CONFIDENTIALITY OF PATIENT RECORDS (42 CFR PART 2)

Your insurance company requires that patient consent be obtained by the provider including consent to disclose information to your insurance company for claims payment purposes and for the provision of healthcare operation activities as provided for in 42 CFR part 2. Part 2 regulations cover any information, including information on referral and intake about patients receiving diagnosis, treatment or referral for treatment for a substance use disorder, created by a part 2 program. By signing below, you are acknowledging you have read, understand and consent to have your information shared with your insurance company.

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

CLIENT RIGHTS

Every client shall have the following rights, none of which shall be abridged by the outpatient client or any of its staff. The agency Administrator shall be responsible for developing and implementing policies to protect client rights and to respond to questions and grievances pertaining to client rights. These rights shall include at least the following:

1. Every client or his/her designated representative shall be informed of the client's rights and responsibilities in advance of furnishing or discontinuing client care.
2. The right to have a family member, chosen representative, and/or his or her own physician notified promptly of admission to the agency.
3. The right to receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment.
4. The right to be treated with consideration, respect, and recognition of their individuality, including the need for privacy in treatment.
5. The right to receive as soon as possible the services of a translator or interpreter to facilitate communication between the client and the agency's health care personnel.
6. The right to participate in the development and implementation of his/her plan of care.

7. Every client or his/her representative (as allowed by state law) has the right to make informed decisions regarding his/her care.
8. The client's rights include being informed of his/her health status and being involved in care planning and treatment.
9. The right to be included in experimental research only when he/she gives informed, written consent to such participation or when a guardian provides such consent for an incompetent client in accordance with appropriate laws and regulations. The client may refuse to participate in experimental research, including the investigation of new drugs and medical devices.
10. The right to be informed if the staff has authorized other health care and/or educational institutions to participate in the client's treatment. The client shall also have a right to know the identity and function of these institutions.
11. The right to be informed by the agency staff and other providers of health care services about any continuing health care requirements after the client's discharge from the agency. The client shall also have the appropriate agency staff in arranging for required follow-up care after discharge.
12. The right to consult freely and privately with his/her parent(s) or legal guardian(s)
13. The right to consult freely and privately with legal counsel as well as the right to employ legal counsel of his/her choosing.
14. The right to make complaints without fear of reprisal.
15. The right to have the individual client's medical records, including all computerized medical information, kept confidential.
16. The right to access information contained in his/her medical records within a reasonable timeframe subject to the exception contained in §9035.L.I.F
17. The right to be free from all forms of abuse and harassment.
18. The right to receive care in a safe setting.
19. The right to be informed in writing about the agency's policies and procedures for initiation, review, and resolution of client complaints.
20. In addition to the rights listed herein, clients have the rights provided in the Louisiana Mental Health Law.

Clients who meet the facility's admission criteria shall not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual preference, or political beliefs.

- Clients may present complaints or suggested changes in Program policies and service to facility employees, governmental officials, or another person within or outside the program. In this process the facility shall not in any way restrain the Client.
- Clients have the right to give prior informed consent for the use and future disposition of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, video, or photographs.

- Fingerprints may be taken and used in connection with treatment or research or to determine the name of a Client only with written consent from the Client, the Client's parent or legal guardian if a minor, or the Client's curator if interdicted. This information must be destroyed or returned to the Client when the fingerprints are no longer essential to treatment or research.
- No audio-visual recording will be done without written consent.
- In addition to the right to treatment, Clients also have the right to file complaints regarding discrimination and service delivery if they feel it is indicated.
- Clients have the right to refuse treatment.
- Clients have all of the rights listed in LA R.S. §28:171 and LA R.S. §40:1079.2
- Clients are notified in writing of their rights.

_____ _____
Client Signature (or Parent/Guardian if Client is a minor) Date
☐ **Client provides consent via virtual signature.**

MINOR'S RIGHTS

Minors and their representatives have all of the rights stated above and those included in the CHC §1409. In Louisiana under LA R.S. §40:1079.2, minors have the right to seek treatment for substance abuse without parental consent or knowledge. Only the consent of the client (even in the case of a minor) is required to provide such treatment. Although the clinician may share information with the parent or legal guardian of a minor (with or without the minor's consent), he/she is not obligated to do so.

_____ _____
Client Signature (or Parent/Guardian if Client is a minor) Date
☐ **Client provides consent via virtual signature.**

FINANCIAL AGREEMENT

This is an agreement between Tanya Stuart, as the therapist/creditor, and the Client/Debtor named on this form. In this agreement the words "you", "your" and "yours" mean the Client/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited, the words "we", "us", and "our" refer to the counseling practice of Tanya Stuart. By executing this agreement, you are agreeing to pay for all services that are received. **PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE.** You may pay by cash, credit or debit card, or check on the day that services are rendered.

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Required payments: Any co-payments, deductibles or coinsurance required by an insurance company must be paid at the time of service. Because copays are an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $25) for any checks returned by the bank. A certified mail fee may also apply if a check is not paid once re-deposited to the bank. Two or more returned checks will result in the account being placed on a cash only status. Checks reported to the Justice of the Peace and/or Police Department may include possible discharge from the practice.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. I give permission to email account information to the following email address _____. I understand there may be information in reference to my diagnosis, date of service, and amount paid for the session.

Text Communication: Text message communication is only for appointment scheduling purposes. It is not for psychiatry services, counseling services or emergencies. For emergencies, call 911 or go to your nearest emergency room.

Initial: _____

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt, including involving collection agencies and possible discharge from the practice.

Waiver of confidentiality: You understand if this account is submitted to an attorney, collection agency or reported to a credit reporting agency, the fact that you received treatment at this practice may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Cancelation Notice: *There is a charge for failed appointments/late cancelation if less than 48-hour notice is given. You will be billed $100, which will be charged using the credit card on file.*

Initial: _____

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in force and effect.

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

_____ _____

Witness Date

☐ **Witness provides consent via virtual signature.**

Genesis Behavioral Health Services
433 Metairie Rd, Suite 520, Metairie, LA 70005

TELEHEALTH INFORMED CONSENT AGREEMENT

This agreement adds to the information and agreements from the Patient- Psychiatrist Agreement which you have previously read and signed during your initial intake.

Virtual “face-to-face” sessions or VC (Video Conferencing) is a real-time interactive audio and visual technology that enables a clinician to provide mental health services remotely. Treatment delivery via VC may be a preferred method due to convenience, distance, or other special circumstances. The VC system used in my practice, Zoom, meets HIPAA standards of encryption and privacy protection. You will not have to purchase a plan when you “join” an online meeting.

Instructions to sign in will be given to each client by their psychiatrist or a staff member.

Please read and note that:

- There are many benefits and some risks of video-conferencing that differ from in-person sessions.
- Confidentiality agreements that are always integral to your care, are the same for telehealth services.
- Recording of sessions is NOT permitted.
- A webcam or a smartphone needs to be used during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is imperative that no family member or friend is in hearing or visual proximity to you or to your electronic device during the session.
- It is important to have a secure internet connection rather than public/free Wi-Fi.
- In order to be punctual please set up for the appointment at least 5 minutes before it is due to begin. You will be admitted to a virtual waiting room.
- A back up plan in the event of technical problems may include restarting the session, or more likely supplementing with a phone for audio.
- Our safety plan includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, the permission and contact information of your parent or legal guardian is required for you to participate in telehealth sessions.
- It is recommended that you confirm with your insurance company that video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychiatrist, I may determine that due to certain circumstances, telehealth is no longer appropriate for you, and that we should resume our appointments in-person.

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By signing this document, you are stating that you are aware that I may contact the necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider or at the nearest hospital emergency department or by calling 911.

Below, please include the names and telephone numbers of your local emergency contacts (including local physician; crisis hotline; trusted family, friend, or confidant).

Emergency Contact #1 Name and Phone Number:

_____

Emergency Contact #2 Name and Phone Number::

_____

Nearest Emergency Room Name and Address:

_____

Crisis Hotline or Crisis Center Phone #s: call 911, text or call 988 Suicide and Crisis Lifeline

Your signature here below indicates that you have read and understood this Telehealth Informed Consent Agreement.

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

ELECTRONIC COMMUNICATION DISCLAIMER

Please note that electronic communications is not an entirely secure or confidential form of communication. Submitting this form electronically to Genesis Behavioral Health Services, constitutes understanding and implied consent of the risks of electronic communication.

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

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OUT OF NETWORK

Any insurance outside of the listed companies above will NOT be billed by the facility. Genesis will provide a-superbill, for services rendered and paid, in order for the policy holder to submit through insurance. Genesis will NOT be responsible for the determination of decision for reimbursement. It is the responsibility of the card holder to contact their insurance company and clarify if an authorization is needed to file an out of network claim.

This is agreed upon with the policy holder that it will be their responsibility to seek reimbursement and/or coordinate with their claims department.

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

DRUG SCREENING PAYMENT INFORMATION

I am aware that Genesis Behavioral Health Services will submit the drug screen for payment on my behalf through my insurance company. I understand that it is my responsibility to understand what my insurance policy covers in reference to lab work. I acknowledge that I am responsible for any payments owed to Accu Reference Medical Lab or Clinical Pathology Laboratories.

_____ _____

Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

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GRIEVANCE POLICY

The agency will encourage feedback from the recipients of its services. The agency will establish guidelines for resolving Client complaints about service or quality of care issues. These guidelines will provide for a timely resolution of complaints through an efficient complaint resolution process.

Initiating a Complaint: When a Client is dissatisfied with the services he/she received from Agency Employees, the Client will be encouraged to discuss his/her dissatisfaction with the Administrator and/or the Clinical Director. The Client will not incur prejudice or penalty as a result of initiating the complaint. Clients will be encouraged to file complaints detailing their dissatisfaction.

If your complaint involves:

Billing issues involving private insurance:	Please read this complain to your individual insurance representative or to the Louisiana Department of Insurance 800-259-5300 **Louisiana Department of Health/Health Standards Section does not intervene in billing issues.**
Billing Issues Involving Medicaid:	Louisiana Medicaid Hotline at 800-488-2917 **Louisiana Department of Health/Health Standards Section does not intervene in billing issues.**
Billing Issues Involving Medicare:	1-800-Medicare **Louisiana Department of Health/Health Standards Section does not intervene in billing issues.**
Physician Practices:	Please refer to your complaint to the Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans LA 70130, 504-568-6820 **Louisiana Department of Health/Health Standards Section does not have authority over physicians.**

Please mail this form to:
Louisiana Department of Health, Health Standards Section
Complaint Program Desk
P.O. Box 3767
Baton Rouge, LA 70821
You may also fax this form to: (225) 342-5073

To receive a complete copy of the "Grievance Policy" with Genesis Behavioral Health Services/Holistic Solutions please request from staff.

_____ _____
Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

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433 Metairie Rd, Suite 520, Metairie, LA 70005

CREDIT CARD AUTHORIZATION FORM

The card will be charged in accordance with our office and cancellation policies.

Credit Card Information

Name as is appears on the card: _____ Phone: (____)_____-_____

Type of Card: ❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: ____/_____

Security Code BACK of Visa OR Master Card (3 digits): _____

Security Code FRONT of Amex Card (4 digits): _____

Billing Address: _____
City State ZIP

I hereby authorize this card to be used for payment of services rendered and future services rendered.

_____ _____
Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

***If using Adobe to submit this form, simply click Submit Form and send using your default email application or webmail preference. If not using Adobe to submit this form, please save the completed form, attach it to a new email, and send to charlottel@beaconbh.com. After either option, please check you sent email folder to confirm it has been sent.*