Stephanie C. Badon

Psychiatric Mental Health Nurse Practitioner - BC

124 Main St. Ste 101
New Iberia LA 70560
ph: 337-606-3988 fax: 800-867-6270
sbadonpmhnp@gmail.com

Please return the completed form(s) by email, fax, USPS mail, or in person. One of our team members will contact you as soon as possible.

Your journey to mental wellness starts *here* .

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sbadonpmhnp@gmail.com

Date:_____

Patients Name:_____ Date of Birth: _____

Mailing Address:_____

City:_____ State: _____ Zip:_____

Cell:_____ Home:_____

SSN:_____ Sex: ☐ Male ☐ Female

Occupation: _____

Primary Insurance

Carrier Name:_____

Subscriber Name:_____ DOB:_____

Employer: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance

Carrier Name:_____

Subscriber Name:_____ DOB:_____

Employer: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Emergency Contact Information

Name:_____ Relationship:_____

Phone:_____

Spouse/Partner Name:_____ Phone:_____

I understand that my signature below certifies the information to Stephanie C. Badon is accurate and current.

_____ _____

Signature of Patient or Parent if Minor Date

Allergies to Medications

Current List of Medications Medical Problems

Family Physician

History of Surgeries

Have you ever received Psychiatric Care ? _____ yes _____ no
If so, with whom? _____

Pharmacy _____
Pharmacy Phone Number _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Date of Request: _____

Name: _____DOB: _____SSN:_____
Address: (street, city, state, zip)

_____
Phone: _____
__ I, _____, authorize:

Stephanie C Badon, PMHNP-BC
124 E. Main St. Ste 101
New Iberia, LA 70560

☐ To Release information to: ☐ To Obtain information from:

Person/Entity_____
Address _____
City State Zip _____
Phone _____Email _____

The Purpose of this Authorization is indicated in the box(es) below.
(Place an "X" in the box(es) that apply.)
☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for a disclosure to a third party
☐ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or obtained)
☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports
☐ Treatment or Tests ☐ Prescriptions ☐ Immunizations
☐ Hospital Records including Reports ☐ Lab Reports
☐ Radiology Reports
☐ Other: (Specify) _____
In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
☐ Alcoholism ☐ Drug Use ☐ Mental Health ☐ Vocational Rehab ☐ HIV (AIDS)
☐ Sexually Transmitted Disease ☐ Genetics ☐ Psychotherapy Notes
☐ Other: (Specify) _____
This authorization shall expire on _____(date or event) and is needed for the period beginning _____and ending _____.
I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed. I acknowledge that I have read and understand this entire form. I authorize a copy (including electronic, oral, or paper) of this form for the disclosure of the information described above.

Patient Signature or Authorized Representative_____
Date _____

Stephanie C. Badon
Psychiatric Mental Health Nurse Practitioner - BC

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ph: 337-606-3988 fax: 800-867-6270
sbadonpmhnp@gmail.com

AUTHORIZATION FOR VERBAL COMMUNICATION & TEXT COMMUNICATION AND/OR TO LEAVE Voice Mail Messages & Text Messages

This does NOT authorize release of copies of medical records

BY SIGNING THIS FORM YOU ARE ALLOWING OUR OFFICE TO LEAVE VOICE MESSAGES on Voicemail & TEXT MESSAGES On Cell Phone

Patient Name _____

Street Address_____

City State Zip_____

Date of Birth _____

Phone Number _____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Stephanie C. Badon honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to Stephanie C. Badon: If mailing an authorization, mail to:
Stephanie C. Badon, PMHNP-BC
124 E. Main St. Ste 101
New Iberia, LA 70560

Verbal Communication/ Text Communication only. This authorization allows for verbal and cell phone text communication between Stephanie C. Badon and the designated person on this form. It does not allow for copies of medical records to be released. No Obligation to Sign. You are not under any obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, Stephanie C. Badon may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed previously have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim.

Your revocation must be made in writing and addressed to:
Stephanie C. Badon, PMHNP-BC
124 E. Main St. Ste 101
New Iberia, LA 70560

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical Information without your prior permission.

Voice Mail Messages/ Text Messages

Enso Psychiatric Services providers and their staff recognize confidentiality as a very important part or your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.

___I give my permission to leave a voice mail message at the number listed above.
___I give my permission to leave a text message at the number listed above.

Optional: (Additional person to leave message with)
I also give my permission to leave a message with (NAME)
_____ at the following phone number
_____

What type of message may we leave on your voice mail/ text message:
____ reminder of appointment date and time
____ message to return office call re: labs, scheduling, billing

This authorization will expire in one year from signature unless otherwise indicated below:
___ Indefinite Ends on date:_____

Signature of Patient/Representative_____
Date _____
Relationship to patient:
_____

Patient Rights and Responsibilities

As a patient of **Stephanie C. Badon, PMHNP-BC**, you have the right to privacy and confidentiality regarding your health care. Thank you for giving us the opportunity to best serve your needs and allowing us to provide your mental health services.

As a patient, you have the following rights:

1) The Right to Privacy and Confidentiality: All records and communication regarding your health information will be kept secure and confidential in compliance with state and federal laws. Under state and federal law, there may be times when confidentiality may have to be broken and health information disclosed to certain parties. This includes cases in which someone is a danger to themselves or others, is involved in domestic violence, or there is suspicion of abuse or neglect. We may also be mandated to report your health information by court order or when it is necessary to prevent or lessen an
imminent threat to the health or safety of a person or the public. With your authorization, we may also disclose your health information to an insurance company for payment of services. This may include submitting diagnoses which describe mental health disorders that you may meet the criteria for under the DSM-V/ICD10. This information may be accessed via paper claims or electronic claims that are submitted directly to your insurance company or stored in an electronic system that other insurance companies may access when we apply for a certain insurance panel. If you do not wish to release this information,
you must then pay cash for services rendered.
2) The Right to Medical Records: You may request a copy of your medical records pertaining to your treatment. A reasonable copy fee may be applied.
3) The Right to Account Information: You may request an accounting of certain disclosures that are made of your health information. A reasonable fee may be applied.
4) The Right to Clear Instructions and Up-to-date Information: We will make it a priority to clearly explain your diagnosis,prognosis, treatment options, the risks and benefits of treatment, the nature and purpose of certain tests and procedures,prescribed therapy and/or medications, the need for follow-up visits, the need for other mental health or medical professionals as referrals, and any additional measures to achieve desired outcomes for you.
5) The Right to Accept or Refuse Treatment Recommendations.
6) The Right to Seek Additional Professional Opinions.
7) The Right to a Safe Environment.
8) The Right to Professionalism and Courtesy.
9) The Right to Continuation of care - Please note that we will refer you to another practicing mental health provider, mental health clinic/hospital, or emergency service(s) in the event that Stephanie C. Badon is not available or able to treat you.

As a patient, you have the following responsibilities:

1) Contact your treatment provider for any serious situation that arises regarding your mental health.
2) Provide correct and complete information about your health.
3) Follow the treatment plan to achieve your treatment goals.
4) Advise your treatment provider of any changes in your health conditions.
5) Be respectful of the rights of other patients and building/office personnel.
6) Arrive for your scheduled appointment on time and notify the office if you are unable to make your appointment.
7) Meet the financial obligations for your care.

*** By signing below, you acknowledge that you have read, understood, and agree with the above policies and information. ***

Patient Name: _____Date of Birth:_____

Signature: _____Date: _____

Stephanie C. Badon, PMHNP-BC
Prescription Refill Policy

Stephanie C. Badon, PMHNP–BC, participates with electronic prescribing directly to your mail order and local pharmacies. My goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, I have created the following guidelines to help meet these goals.

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
2. Medication refills will only be addressed during regular office hours (Monday – Thursday, 8am – 4:30 pm and Fridays 8am - 12 noon) . Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.
3. Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment. I prefer you request any refills of your medications at the beginning of your office visit.
4. Patients requesting new prescriptions must be seen for an appointment.
5. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.
6. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
7. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.
8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.
9. We reserve the right to charge an administrative fee for if there are multiple requests for prescriptions requested outside of a visit.

*** By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information. ***

Patient Name:_____ Date of Birth: _____

Signature: _____Date: _____

Stephanie C. Badon, PMHNP-BC
CONTROLLED SUBSTANCES POLICY

- I follow recommended dosing guidelines for controlled medications used to treat anxiety, ADHD, and insomnia.
- Patients being prescribed controlled substances agree to the possibility of being required to do random toxicology screens in order to get prescriptions of controlled substances.
- I may request medical records from recent prescribers before prescribing any psychiatric medications
- I do not prescribe pain medications, muscle relaxants, or medical cannabis.
- If you are taking narcotic pain medications, medical cannabis, or are abusing drugs or alcohol our providers may not prescribe controlled substances to you.
- No controlled substance medications will be prescribed without an in person appointment with a prescriber and regular follow up appointments.
- Taking controlled substances other than how it is prescribed is grounds for termination of care.
- Positive toxicology screens are grounds for termination of care.

*** By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information. ***

Patient Name:_____ Date of Birth: _____

Signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES
Patient HIPPA Acknowledgement and Consent Form

Patient Name: _____ DOB: _____

_____ (Patient Initials) Notice of Privacy Practices.
I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/ or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Stephanie C. Badon, PMHNP-BC is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about the privacy practices of, please contact: *Stephanie C. Badon, PMHNP-BC 124 E. Main St. Ste 101 New Iberia LA 70560*

I. How Stephanie C. Badon, PMHNP-BC May Use or Disclose Your Health Information
Stephanie C. Badon collects health information from you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of Stephanie C. Badon but the information in the medical record belongs to you. Stephanie C. Badon protects the privacy of your health information. The law permits Stephanie C. Badon to use or disclose your health information for the following purposes:
1. Treatment. Medical information about you may be given to doctors, nurses, technicians and medical personnel who are involved in providing your care.
2. Payment. Medical information about you concerning the treatment and service received will be billed either to the patient or the patient's insurer. Your health plan or third-party payer may request information from your medical record to authorize prior approval or certification for service.
3. Regular healthcare care operations. Information about you may be used in order to review treatment and services and in order to evaluate the performance of the staff.
4. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
5. Required by law. As required by law, we may use and disclose your health information.
6. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling injury or disability, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease of infection exposure.
7. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
8. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
9. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
10. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

II. Stephanie C. Badon, PMHNP-BC may not use or disclose your health information except as described in this Notice of Privacy Practices without your written authorization. If you do authorize me to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Stephanie C. Badon is not required to agree to the restriction.
2. You have the right to receive your health information through a reasonable alternative means. You will have to have a written authorization, specification of method (email or mail), and payment method if applicable.
3. You have the right to inspect and copy your health information.
4. You have the right to request Stephanie C. Badon amend your health record that is incorrect or incomplete. We are not required to change your health information and will provide you with information about our denial and how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your health information made by Stephanie C. Badon except for the uses and disclosures listed in section I of the Notice of Privacy Practices.
6. You have the right to a paper copy of the Notice of Privacy Practices.

IV. Changes to this Notice of Privacy Practices

Stephanie C. Badon reserves the right to amend Privacy Practices at any time in the future and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Stephanie C. Badon is required by law to comply with this Notice. Whatever the reason for these changes in the Privacy Practices I will provide you with a revised notice on your return appointment.

V. Complaints

Complaints about this Notice of Privacy Practices or how Stephanie C. Badon handles your health information should be directed to:

HIPPA Privacy Officer/ Office Manager
124 E. Main St. Ste 101
New Iberia LA, 70560

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 F
Washington, DC 20201

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I received, reviewed, and understand the copy of Stephanie C. Badon, PMHNP-BC's Notice of Privacy Practices.

_____ _____
Patient's Signature Date

_____
Patient Name

_____ _____
Signature of authorized agent (if applicable) Date

_____
Authorized Agent Name (if applicable)

Stephanie C. Badon, PMHNP-BC
HIPPA CONSENT FORM

PATIENT NAME _____ DOB _____

_____ (Patient Initials) **RELEASE OF INFORMATION**
I hereby permit the practice/ health care professionals involved in my care to release healthcare information for the purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage payment questions or for any other purpose related to benefit payment. Healthcare information may also be released to my employer designer when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports , progress notes, consultations, psychiatric reports, drug and alcohol treatment, and discharge summary.

Disclosures to Friends and/ or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

Patient may revoke or modify this specific authorization and that revocation or modification MUST be in writing.

Consent for Treatment: I authorize Stephanie C. Badon to render to the patient all customary care, therapy, treatment, considered advisable, including emergency treatment and transportation to another facility if necessary. The undersigned acknowledges that the patient is under the care of a healthcare provider and Stephanie C. Badon is not liable for any act or omission in the following instructions of said provider. The undersigned further recognizes that the patient is responsible for any health insurance deductible, federally mandated co-insurance, and non-covered charges for services provided.

Consent for Release of Information: I authorize Stephanie C. Badon to release all patient information, including specific information regarding diagnosis, treatment and prognosis with respect to any physical, psychiatric, or drug/ alcohol related conditions for which patient is being treated, including treatment for Acquired Deficiency Syndrome (AIDS), while a patient of Stephanie C. Badon, to any insurance company, and/ or third party payors, or representatives providing coverage for services, to any appropriate representative of the practice including, but not limited to contract employees (as applicable by HIPPA laws), other health care professionals, or organizations. This information may not be released to any other person or entity *unless* the undersigned so authorizes.

*I acknowledge that such disclosures shall be limited to information that is responsible necessary for the billing of the legal or contractual obligations of the person (s) or entities to which information is released.
*I further authorize Stephanie C. Badon to release information for the purpose of obtaining pre-authorization for treatment, to release information to medical review agencies, and/ or to third party payors providing coverage or having responsibility for these services.

Guarantee of Payment/ Financial Responsibility: I hereby agree to guarantee the payment of the bill for services rendered by Stephanie C. Badon. I agree whether signing as guarantor or as a patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account ina accordance with the regular rates and terms of the practice. I agree that I am responsible for any health insurance deductible, federally mandated co-insurance, and non-covered charges. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount not paid when due.

Assignment of Insurance Benefits: In consideration of medical services rendered or to be rendered by Stephanie C. Badon to the extent permitted by law, I hereby (I) irrevocably assign, transfer, and set over to Stephanie C.Badon (II) all of my rights, title and interest to medical reimbursement, including but not limited to (III) the right to designate a beneficiary, add dependency eligibility and (IV) to have an individual policy continued or issue in accordance with terms and benefits under any insurance policy subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by the practice during the pendency of the claim. Such irrevocable assignment and transfer shall be for the recovery of said policy/ policies of insurance, but shall not be construed to be an obligation of cooperation to pursue any such right of recovery. I hereby authorize the insurance company or companies their party payor (s) to pay directly to Stephanie C. Badon all benefits due for services rendered.

I understand that my signature below certifies that the information provided to Stephanie C. Badon is true and correct to the best of my knowledge. I have read and understand the above consents and/ or statements.

_____ _____

Print Patient Name Signature of Patient/ Guarantor/ Or Legal Guardian

Date: _____

Financial and Appointment Adherence Agreement
Stephanie C. Badon PMHNP-BC

1. Fees for services:
a. Psychiatric Evaluation (45-60 minutes) - $250
b. Medication Management follow-up (15 minutes) - $125
a 3% service charge will be added when using a credit/debit card for payment
2. All patients are required to pay in full for the service rendered at the time of the appointment. Refunds will not be issued under any circumstances.
Account balances must be paid in order to schedule follow up appointments.
3. Cancellation policy: Appointments must be canceled at least **twenty-four (24) hours** in advance of your scheduled appointment or you will be charged a **no-show feel of $50** for follow up appointments. This fee is NOT covered by insurance. This must be paid in full before the next visit can be scheduled. If your contact information changes between visits, it is your responsibility to contact my office to avoid any fees. I can be notified of your intent to cancel an appointment by office phone (337-606-3988) or through the automatic text messaging system. Reminder calls and/or texts to my patients are not guaranteed and are offered as a courtesy only.
4. I have the right to discharge patients at any time. However, patients who miss two (2) or more appointments without **24-hour notification** or are 10-minutes-or-more late for their scheduled appointment on two (2) or more occasions will be given warning of discharge from the practice for noncompliance upon the third (3) occurrence. Under these circumstances, the patient will be mailed a written letter of notification. There are circumstances in which exceptions may be made to this policy upon the discretion of the provider. This policy is in place out of respect for the provider and their patients. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone from being able to schedule into that time slot.
5. I am happy to fill out various forms for our clients. There is a $20 fee for this service. This fee is not an insurance billable charge and is the client's responsibility. Alternatively, the provider may require that you schedule an appointment for completion of forms.
6. Medical Record Copying Fees:

- Search Fee = $25.00
- Pages 1-25 = $1.00 per page
- Pages 26-350 $0.50 per page
- Pages 351+ = $0.25 per page

7. Questions: You are encouraged to call my office if there are any questions about this information. If financial problems arise at any time while under the care of Stephanie C. Badon, you are encouraged to speak with my office.
8. Payment for services can be made by cash, check, or credit/debit card. Checks should be written to Stephanie C. Badon.
9. Checks that are not cleared by the bank for any reason will be assessed a $35 service charge. A charge will then be made to the credit card we have on file for you to cover the amount of the check and the service charge. All NSF checks written are subject to collection action.

Thanks kindly in advance for your cooperation.
*** By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information. ***

Patient Name:_____ Date of Birth: _____

Signature:_____

Credit Card Authorization Form (keep on file)
Stepahnie C. Badon PMHNP-BC
124 E. Main St. Ste 101 New Iberia LA 70560

This form is for you to supply Stephanie C. Badon with credit card information to keep on file for the payment of all services and fees. A new form must be completed for each card kept on file.

Fees can include but are not limited to:
Office visit fee
Co-payment fee
Late or No Show Fee as per office policy
Medical records fee
NSF service charge

Patient Name _____

Cardholder Name (if different from patient) _____

Card Type: Visa ☐ Mastercard ☐ Discover ☐ AmEx ☐

Credit Card Number: _____
Name as it appears on card: _____
Security Code (3 digit # on back of card): _____
Expiration Date: _____

Cardholder Signature_____

Date _____

**Please list anyone other than the cardholder that is authorized to use this credit card:
Name _____ Signature _____

Please accompany this form with a copy of your driver's license or photo ID as well as for any and all parties listed above.

I authorize Stephanie C. Badon to charge the credit card listed above for payment for all services and fees. This credit card will be kept on file and will remain in effect until expiration of the credit card account. I understand that I may revoke this credit card on file by submitting a written request to the address at the top of this form. A new form must be submitted if any information such as credit card expiration or authorized users are amended. I agree to pay the cost for any returned or challenged payments. I also understand that a service charge of 3% will be assessed for each credit/debit card payment.

Patient Signature _____ Date _____

Informed Consent for Tele-Medicine Services
Stephanie C. Badon, PMHNP-BC 124 E. Main St. Ste 101 New Iberia LA 70560

Patient Name _____ DOB _____

Address

_____

_____

I understand that the tele-medicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/ she is located at a different site than the provider; and hereby consent to Stephanie C. Badon providing health care service to me via tele-medicine.

I understand that the laws protecting the privacy and confidentiality of medical information also apply to tele-medicine. As always, your insurance carrier will have access to your medical records for quality review/ audit. Should you need medical records, please contact our office at 337-606-3988.

I understand that I will be responsible for any co-payments or co-insurances that apply to my tele-medicine visit.

In the event of technology failure, please call our office to schedule an in person appointment. If it is an emergency, please go to the local hospital.

I understand that I have the right to withhold or withdraw my consent to the use of tele-medicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent verbally or in writing at any time by contacting:

Stephanie Badon, PMHNP-BC
124 E. Main St. Ste 101
New Iberia, LA 70560
337-606-3988

As long as this consent is in force, Stephanie C. Badon may provide health care services to me via tele-medicine without the need for me to sign another consent form.

Signature _____ Date _____