Welcome to Stepping Stones Psychiatric Care

Stepping Stones Psychiatric Care practice is primarily focused on the treatment of disorders affecting a patient's mood, feelings and ability to function, etc. The clinic offers nontraditional hours to decrease time away from school or work. We value the importance of education and the client's time. We feel excess time away from work or school may cause undue stress and require use of personal time away that could better be utilized for vacation or self-care.

- **Nurse Practitioner, Julie Burke is a board-certified advanced practice nurse specializing in psychiatric mental health nursing. She received her Master's in Nursing from Georgia State University. She is a dual certified Psychiatric Mental Health Clinical Nurse Specialist and Psychiatric Nurse Practitioner. She treats patients across the life span. She is involved with and supervises the treatment of all clients within the practice.**

- **Nurse Practitioner, Retta Bright is a board-certified advanced practice nurse specializing in the psychiatric mental health nursing. She received her Master's in Nursing from GA State University, in Atlanta, GA. She is dual certified as a psychiatric Nurse Practitioner and Family Nurse Practitioner. She treats, adolescents and adults.**

- **Dr. Jennifer Beckman Richason MD is a board-certified psychiatrist by the American Board of Psychiatry and Neurology. Dr. Richason graduated with her medical degree from University of South Florida College of Medicine in Tampa Fla. She completed her internship and residency training in psychiatry at Wake Forest University in Winston-Salem NC.**

- **Dr. Eugenio MD is a board-certified psychiatrist by the American Board of Psychiatry and Neurology. Dr. Eugenio graduated with his medical degree from University of Manila, and he completed his internship and residency at Meharry Medical College in Nashville, TN.**

Our Nurse Practitioners, maintain an open communication and ongoing collaboration with Dr. Richason and Dr. Eugenio. They may consult with other providers involved with your treatment and will make referrals when needed.

We as a clinic feel strongly that mental health issues are best treated with combination therapy involving both medication and psychotherapy. We believe that treatment of the mind, body and spirit is crucial in achieving overall wellbeing. We recommend that each patient develop a close therapeutic relationship with a licensed individual psychotherapist.

We are glad you have chosen us for your mental health needs and cannot wait to serve you!

Stepping Stones Psychiatric Care LLC.

2020 Policies & Information Forms

Patient information:

Today's Date: _____ **Email:** _____

Name: _____ **DOB:** _____

Mailing Address: _____ **Age:** _____

City, State, Zip: _____ **SSN:** _____

Phone: _____ **Marital Status: Married ( ) Single ( ) Divorced ( ) Other ( )**

In case of Emergency, Notify: _____ **Sex: Male ( ) Female ( )**

Phone: _____ **Referred by:** _____

Relationship to patient: _____ **Phone:** _____

Insurance Information

Primary Insurance: _____ **Secondary Insurance:** _____

ID Number: _____ **ID Number:** _____

Mailing Address: _____ **Mailing Address:** _____

City, State, Zip: _____ **City, State, Zip:** _____

Name/Policy Holder: _____ **Name/Policy Holder:** _____

SSN: _____ **SSN:** _____

DOB: _____ **DOB:** _____

Prescription card if separate RX Bin_____ **PCN**_____ **Group**_____

Employment Information

Employer: _____ **Telephone:** _____

Mailing Address: _____ **City, State, Zip:** _____

Responsible Party Information

Name: _____

Mailing Address: _____

City, State, Zip: _____

DOB: _____

SSN: _____

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility.

X _____

Responsible Party Signature

Phone: _____

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: _____ **Date:** _____

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ **Date:** _____

Prescriptions and After hours

Any calls before and after office hours will be returned the next business day.

If it is a medical emergency or you are in crisis, please report to your nearest emergency room.

No prescriptions will be filled outside of office hours.
Medications will only be adjusted,
Added or changed during visits

All controlled substances require a random drug screen

Prescriptions for controlled substances cannot be replaced if lost or stolen

Missed Appointment Policy

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled **24 hours** in advance. Our providers want to be available for your needs and the needs of all our patients. If you frequently reschedule or no show, it will result in consideration of closure to your chart.

If you miss a scheduled appointment you will be responsible to pay $90.00 fee.
This fee is **not covered by insurance** and is the patient's responsibility. This fee will need to be paid before we make your next appointment.

You can reschedule or cancel your appointment by phone call or text.

By signing this agreement, you understand the importance of scheduling an appointment upon leaving the office.

Patient/Guardian Signature:_____
Witness: Erin Hicks_____
Date:_____

.

Medication and Office Policy

By initialing and signing this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible.

_____ 1. I am aware that the use of such medicine has certain risks if I stop taking them without notice or advising the physician.

_____ 2. I understand that the main treatment goal is to be compliant with my treatment and appointments. In consideration of that goal and the fact that I am being given medication to help me reach that goal.

_____ 3. I agree to tell my doctor about all medication and treatments that I am receiving currently. **I will not abuse controlled substances/medications that I am given from my practitioner/physician.**

_____ 4. I understand the following refill policy:

a. ***In order to get your medication, you need to be compliant with your appointments***
b. ***If you miss your appointments or no show and you are out of medication you will be allowed only 5days worth of medication and it is your responsibility to get a appointment as soon as possible for more medication.***

_____ 5. I agree to **keep all scheduled appointments** at all times.

_____ 6. I may be asked to give a urine sample for the purpose for medication management, prior to seeing the practitioner. .

_____ 7. I agree to handle all my prescribitons with care, For controlled substances, providers **will not reissue another one if lost or misplaced.**

_____ 8. I will give the office 24 hour notice if I am unable to keep my schedule appointment ,we have a very high call volume of patients and each patient time is valuable. **(I am aware there is a $90 no show fee policy).**

_____ 9. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.

_____ 10. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for him or herself.

_____ 11. **I understand that I am responsible for any copays, deductibles, coinsurance or remaining balances after insurance has paid for services rendered. I agree to pay the remaining balance after insurance payments up to the negotiated amount of insurance.**

_____ 12. **I understand that if I fail to comply** with the office policy's it may cause for the provider to close my chart and I will have to find another provider in this agreement and on my prescription labels; if I obtain similar narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.

CONTROLLED SUBSTANCE POLICY:

To All Patients:

- We *will not* refill prescriptions early or replace lost prescriptions.
- You agree **NOT** to seek the prescription of opioid medications, stimulants or any other controlled prescription drugs from any other physician without the *knowledge* and *consent* of your provider.
- Prescription refills will be authorized only during regular office hours.
- You agree to provide random urine specimens for medication monitoring purposes. Screens will be obtained at regular appointments and a random at the discretion of our providers. Positive tests for any illegal substances or prescription drugs not being prescribed or approved otherwise by our providers *may likely* result in dismissal from the practice.
- It shall be understood to abstain from alcohol consumption while taking controlled substances. Clinic shall not assume responsibility for patient driving or operating heavy machinery while taking medications prescribed by our providers.

Patient or Guardian Signature and date: _____

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

HOW WE MAY USE AND DICLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may disclose your record to an insurance company so that we may get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside of the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your case.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you, and to follow the terms of the notices that are currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could included disclosure to, or for, coroners, medical examiners and funeral directors ; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and workers' compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restriction. You have eth right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restriction, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practices waiting room.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the privacy officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Others uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Stepping Stones Psychiatric Clinic LLC Notice of Privacy Practices (HIPPA).

_____ _____ Date
Patient/Guardian signature

Erin Hicks_____ _____Date
Witness

Treatment Consent Form

Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of The Stepping Stones Psychiatric Care. This form documents that the client has consented to treatment at Stepping Stones Psychiatric Clinic, including but not limited to psychiatric evaluation and psychotherapy with medication management. This allows the professional staff at Stepping Stones Psychiatric Clinic to provide services to you.

This form provides evidence that no guarantee is made by any professional at Stepping Stones Psychiatric Clinic concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at Stepping Stones Psychiatric Clinic. If you have any questions concerning this or any other matters, it is your responsibility to ask your provider. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, _____
(Patient name)

Do hereby voluntarily consent to care and treatment by Julie Burke APRN, Dr. Jennifer Beckman Richason, her assistants and/or designees. I am aware that the practice of medicine, psychiatry, and other therapy by a licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the treatment process and that I share responsibility for treatment. My responsibilities in treatment include informing the provider of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____/_____ _____

(Patient name) ***Guardian signature*** ***(Date)***

Erin Hicks-Office Staff _____

(Witness) ***(Date)***

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____ _____ / / _____
(Patient Name – Please Print) (Patient Date of Birth - MM/DD/YYYY)

authorize **Stepping Stones Psychiatric Care.** , to release protected health information related to my evaluation and treatment to:
(Provider Name – Please Print)

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Patient Rights

- ❖ You can resend(with written signature), this authorization (permission to use or disclose information) any time by contacting:

_____

- ❖ If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- ❖ You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- ❖ Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire, unless another date is specified. I have read and understand the above information

_____ ** I DO NOT want any medical information disclosed to my PCP.**

_____ _____ _____ _____
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization For Use/Release Of Protected Health Information

(1)_____
(Name) (Date of Birth)

_____
(Street Address) (City, State, Zip Code)

I authorized the use and /or release of my protected health information as described in Section 4 below. I understand this authorization is voluntary and is made to confirm my instruction.

(2) ***Authorization To Release From:***

_____
Name

_____
Street Address

_____
City, State, Zip

Fax #:_____

(3) ***Release Protected Health Information To:***

Stepping Stones Psychiatric Care LLC.
Name

3025 Sharpsburg McCullum Road Bld. B, Ste. 103
Street Address

Newnan, GA 30265
City, State, Zip

Fax #: 678-673-6464

(4) Health Information to Be Released For the Following Dates:_____

Include:

___ All Medical Records
___ Billing Records
___ Treatment Plan
___ Evaluation Reports
___ Lab Reports/Radiology Reports
___ Medication List / Diagnostic Material
___ Progress Notes

(5) Expiration: This authorization becomes effective _____/_____/_____ and may be revoked by me in writing at any time except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates one (1) year from the effective date. This will expire one (1) year from the date of my signature below. I further understand that if I am under a criminal justice system referral this cannot be revoked by me until there has been a formal and effective termination or revocation of my release from probation or parole or other proceeding under which I was mandated for treatment.

(6) Understanding and Signature: I further understand that the information authorized by this Release will be released to the authorized receipt only for the purpose noted above. I understand that the information used or released as a result of this authorization may no longer be protected by the federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.

_____ _____
Patient Signature or Legal Guardian ***Date***

_____ _____
Witness ***Date***

Stepping Stones Psychiatric Care
3025 Sharpsburg McCullum Rd. Building B Ste 103 Newnan, GA 30265 Ph: (678)673-6202 Fax: (678)673-6464

Name: _____

DOB: _____

Medical Section

List any previous psychiatric (or alcohol and/or drug treatment) hospitalizations:

Reason for Treatment	Hospital/Place	Treatment Date	Length of Treatment

List any medical or surgical (operations) hospitalizations:

Reason for Treatment	Hospital/Place	Treatment Date	Length of Treatment

Please check the following illness(es) or conditions you have been treated for by a physician:

_____Anemia
_____Arthritis
_____Asthma
_____rectal bleed
_____cancer
_____diabetes
_____Emphysema
_____Seizures
_____headaches
_____gastritis
_____Glaucoma
_____heart attack
_____heart disease
_____hearing loss

_____ Hemorrhoids
_____ Hernia – type _____
_____ High blood pressure
_____ Kidney problems
_____ Liver disease
_____ Pancreatitis
_____ Prostate problems
_____ Skin problems
_____ Thyroid disorder
_____ Tuberculosis (TB)
_____ Ulcers
_____ Head Injury/hx of concussion
_____ Weight change

What medications are you taking, how much, and how often?

Name	How much/often?	Name	How much/often?

Height: _____ Current Weight: _____

Are you allergic to any medications? _____ YES _____ NO

If "YES" list the medicine name (type) and the reaction that you had:

Name (type)	Reaction	Name (type)	Reaction

Health habits (Check all that apply):

_____ Do you drink beer, wine, whiskey, or spirits?
_____ Have you ever felt that you should cut down on your drinking?
_____ Have people annoyed you by criticizing your drinking?
_____ Have you ever felt bad or guilty about your drinking?
_____ Have you ever had a drink in the morning to steady your nerves or to get rid of a hangover?
_____ Have you ever had a ticket while intoxicated? If "yes", how many times?

Times? _____ When? _____

How frequently do you drink?

_____ Daily _____ Twice/week _____ Monthly _____ Other: _____

Do you now, or have you in the past, used marijuana or any other street drug? _____ YES _____ NO

If "yes", what? _____ How often? _____ How long? _____

Do you use tobacco? _____ YES _____ NO If "yes", what, how long, and how much?

Cigarettes/day _____ Pipe/day _____

Cigars/day _____ Chew/dip _____

What is the total number of years you have smoked/chewed? _____

GENETIC SECTION

Please list any biological children of the patient:

First Name	Age	Sex (M,F)	Any health problems (Yes/No)? When?

Have any members of your biological family had mental problems or received mental health or alcohol and drug treatment?

_____ YES _____ NO

If "yes", please describe the symptoms each individual experienced and was treatment helpful:

Relation/Name	Symptoms	Treatment Helpful (Yes/No)

Work Section

Current income situation:

_____ Presently employed full time – Occupation _____

Where: _____ How long: _____

_____ Presently employed part time – Occupation _____

Where: _____ How long: _____

_____ Unemployed – How long: _____ Why: _____

_____ Retired – When _____

_____ Disabled (cannot work) Type of disability _____

_____ Student – What grade/level _____

Stepping Stones Psychiatric Care
3025 Sharpsburg McCullum Road
Building B, Suite 103
Newnan, GA 30265
404-425-2264

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video conferencing services, we discussed and agreed to the following:

• there are potential benefits in risk of video conferencing (e.g. limits to patients' confidentiality) That differ from in-person sessions

• confidentiality still applies for telepsychology services comma and nobody will record the session without the permission from the other persons

• we agreed to use the video conferencing platform selected for our virtual sessions' comma and the psychiatric nurse practitioner will explain how to use it.

• You need to use a webcam or smartphone 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 important to use a secure Internet connection rather than public/free Wi-Fi

• It is important to be on time. If you need to cancel or change your appointment, you must notify the nurse practitioner in advance by phone or email

• we need a backup plan (e.g. phone number where you can be reached) To restart the session or to reschedule it, in the event of technical problems.

• We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis

• if you are not an adult, we need permission of your parent or legal Guardian and their contact information for you to participate in Tele psychology sessions

• you should confirm with your insurance company that video sessions will be reimbursed, if they are not reimbursed, you are responsible for full payment

• as your psychiatric nurse practitioner, I may determine that due to certain circumstances, tell us psychology is no longer appropriate and that we would resume our sessions in person

Psychiatric Provider/ Signature:

Patient name:_____

Signature of patient/patient's legal guardian:_____

Date:_____

Office Witness: Erin Hicks

**ONLY fill out if you are:
Veteran/Tri-west Patient**

Tele-Behavioral Health Protocol

Veteran Name:

Veteran Last 4 of SSN:

Veteran DOB:

Veteran Phone Number:

All locations in which you will/could use for your tele-behavioral health session:

Location description:

Home/work/school/etc.

Location address:

Veteran's Emergency Contact Emergency

Contact Name:

Emergency Contact Telephone Number:

Psychiatric Provider/ Signature: Julie Burke APRN PMH CNS NP BC

Signature of patient/patient's legal guardian: Date:

Witness: Erin Hicks

Credit Card Authorization Form

CARDHOLDER NAME: _____

BILLING ADDRESS: _____

_____

CARD TYPE: _____VISA _____MASTERCARD_____DISCOVER _____AMEX _____HSA

CREDIT CARD #: _____

EXP. DATE: _____

CVV # (BACK OF CARD): _____

BILLING ZIP CODE: _____

CARDHOLDER-Print name, sign, and date below:

Signed: _____

Dated: _____

Name: _____

Please return this form to:
Stepping Stones Psychiatric Care
3025 Sharpsburg McCullum Road
Building B, Suite 103
Newnan, GA 30265

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION & RETURN TO US. THIS IS NOT REQUIRED BUT WILL REMAIN ON FILE IF YOU SHOULD OPT IN FOR AUTOMATIC PAYMENTS, FEES & CO-PAYMENTS. ALL INFORMATION WILL REMAIN CONFIDENTIAL. This form will need to be updated yearly. Please make the office aware of any changes to cards on file.

STEPPING STONES PSYCIATRIC CARE WILL NOT BE HELD RESPONSIBLE FOR ANY FRAUDULENT CHARGES MADE TO THIS CARD ON FILE.