General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Serenity communicates with the patient or guardian regarding appointments and medications via phone and text. If you wish to be able to exchange information with Serenity via email, please be aware of the following: Keep in mind that email is not intended to replace regular communication with your provider. Emails may not be read or responded to immediately. Remember, your condition cannot be diagnosed or treated via email or other written communications. As your email may not be considered secure, please be aware of the security risks, though minimal, when communicating through email. You have the right under the Privacy Rule to request and have your health care provider communicate with you by alternative means. If you prefer not to be contacted by email, we can contact you via mail, fax, or phone.

If you would like to opt out of all email communication such as, but not limited to, appointment reminders, paperwork communication, medical records, PHI, etc. please initial here: _____

If you do not want to allow Serenity to utilize any external medical history as available, please initial here: _____

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative **Relationship to Patient**

Controlled Substance Agreement

Serenity is committed to doing all we can to treat your illness. In some cases, controlled substances are used as a therapeutic option in the management of anxiety states, insomnia, attention problems, and chronic pain (may be prescribed elsewhere), which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the provider by clarifying legal guidelines for proper and controlled substance use.

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family.
2. I will inform Serenity of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
3. All controlled substances must come from the physician at Serenity who is my primary physician or, during his/her absence, by the covering provider, unless specific authorization is obtained for an exception. I understand that I must tell the provider whose signature appears below or, during his/her absence, the covering provider, all medications that I am taking, have purchased, or have obtained. Failure to disclose may result in drug interactions or overdoses that could result in harm to me, including death.
4. I understand it is unlawful to be prescribed the same controlled medication by more than one healthcare provider at a time without each provider's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a provider, or his/her staff, or knowingly withholding facts from a provider or his/her staff (including failure to inform the provider or his/her staff of all controlled substances that I have been prescribed).
5. I will inform my other healthcare providers of any controlled substances I am taking, and of the existence of this Agreement. In the event of an emergency, I will provide the information about my controlled substances to emergency department providers.
6. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, I will inform Serenity of the change.
7. I will not allow anyone else to take, sell, use, or otherwise permit others, including spouse or family members, to have access to any controlled substances that I have been prescribed. The sharing of medications with anyone is forbidden and is against the law.
8. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the provider whose signature appears below or, during his/her absence by the covering provider. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
9. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, etc.

10. Per DEA and govt regulatory requirement, early refills will not be given. Renewals are based upon keeping scheduled appointments. Please call during our regular business hours for refill requests. **Initial_____**
11. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
12. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
13. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this provider.

I have been informed that individuals who are prescribed certain controlled substances including, but not limited to, stimulants, sedatives, hypnotics, and benzodiazepine tranquilizers, have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat my mental health diagnoses.

I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all its terms. A copy of this document can be given to me at my request.

Patient Full Name

Signature of Patient of Guardian **Date**

NO-SHOW/SAME DAY CANCELLATION POLICY

It is our number one priority at Serenity Mental Health to provide the best quality of care to all our patients. We understand that situations come up in life that are out of your control, however we do have cancellation lists full of patients that would like to be seen as soon as possible. Please call and cancel your appointment more than 24 hours in advance if possible, to avoid a no-show fee. The third no-show/same day cancellation of a provider visit will result in termination of care. By signing and dating below, I acknowledge and understand this policy at Serenity Mental Health.

Signature of Patient/Legal Guardian **Date**

Medication Refill Policy

Patients must have a follow up appointment scheduled with their provider for refills to be sent.

•I understand that if I have no-showed, canceled, or rescheduled (1) follow up appointment, a maximum of a 10-day bridge will be sent. Follow up visit MUST be scheduled within 10 days. **Initial_____**

•I understand that if I have no-showed, canceled, or rescheduled (2) consecutive appointments, no refills will be sent and I am not guaranteed a same-day appointment and may need to use emergency services for my medication until I can be seen in office. I understand that if I have 2 consecutive missed appointments, no refills will be sent until I am seen in person. **Initial_____**

Patients can request non-controlled substance refills up to 7 days in advance.

90-day supplies will not be sent on behalf of insurance purposes unless provider has sent out 30 days with refills. If only 30 days was sent, medical necessity for the 30-day supply should be provided to the insurance to get coverage for patients.

Medication refills will only be sent for active prescriptions, medications changes must be reviewed by your provider and may require a return visit prior to sending.

Controlled Medications

Patients must have a follow up appointment scheduled with their provider for refills to be sent.

Providers will authorize early refills on controlled substances (2) days prior to the 30-day mark.

Moving or Switching to New Provider (Outside of Serenity)

•I understand that if I am discontinuing care with Serenity, ONLY a 3-month supply of medications will be sent. Additional refills will not be sent. **Initial_____**

Signature of Patient/Legal Guardian **Date**

Consent to Recording

In order to provide quality care to our patients, to ensure that all providers and members of our staff are properly trained, and to promote the safety of our patients, providers and members of our staff, we may record all interactions within our office. In accordance with FL Stat 934.03 *et seq*. the undersigned hereby consents to being recorded.

Signature of Patient or **Signature of Authorized Representative of Patient** **Date**

Guarantee of Payment and Assignment of Insurance Benefits

1. The undersigned (you) promises to pay Serenity TMS Centers, LLC for all charges incurred and to be incurred for services rendered and/or goods furnished.
2. Payment in full is expected at time of service; including Copays, Co-Insurance, and Deductibles as assigned by your insurance.
3. Any additional services rendered, but not billed on the day of service, or any additional charges your insurance may assign to you, will be your responsibility.
4. Serenity TMS Centers, LLC makes every effort to collect accurate patient responsibility at time of service based on the information provided by your insurance carrier. If you think your bill is incorrect, please call us as soon as possible. If an incorrect amount was collected and you are due a credit, Serenity TMS Centers, LLC will credit your patient account unless requested otherwise.
5. A discounted fee schedule will be applied to all self-pay patients who pay at the time of service. Additional services rendered but not charged at the time of service will be billed at the discounted rate. Payment not received in a timely manner will result in the loss of the discount rate for the outstanding balance. The discounted rate does not apply to patients with insurance. Once services are paid at the discounted rate, they are not eligible for claim submission to your insurance at a later date by Serenity TMS Centers, LLC.
6. Payments made by check may be processed as an electronic debit to your account. Paper checks or electronic debits that fail to clear are each subject to a service charge of $35.00 and may be resubmitted electronically.
7. The undersigned hereby assigns any and all insurance benefits for services provided to Serenity TMS Centers, LLC, and authorizes Serenity TMS Centers, LLC to act as the undersigned's agent in helping obtain payment from the indicated insurance company(s). The undersigned authorizes use of this form on all insurance claim submissions. The undersigned understands that Serenity TMS Centers, LLC will file the patients insurance claim(s) as a courtesy to the patient and authorizes Serenity TMS Centers, LLC to release any and all information necessary to perfect said insurance claim(s) and/or to collect any balance due to Serenity TMS Centers, LLC; however, it is understood and agreed that the patient and/or the undersigned is responsible for payment and/or perfecting and following up on any insurance claims.
8. Any person who, knowingly and with intent to injure, defraud, or deceive an employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, may be punishable under Arizona statutes.

I hereby acknowledge that I have received and read a copy of the organization's Guarantee of Payment Policy. I further acknowledge that I understand and accept the terms thereof and that the information that I have provided is accurate and correct.

Signature of Patient or **Signature of Authorized Representative of Patient** **Date**

Serenity Parenting Policy

We require a custodial parent or guardian to be present for the new patient appointment for children under 18. We require a custodial parent or guardian to be present for each and every appointment for patients under 16.

We require a valid photo identification card of the custodial parent(s), foster parent, or any adult in in which you have submitted a notarized statement indicating they may consent to any and all treatment for that child.

A **valid photo ID** includes any state issued ID card, valid state driver's license, military ID card, or valid government passport.

If a custodial parent is not able to be present, we must have a notarized power of attorney or notarized letter of consent on file giving permission for another adult to be present and consent for the care or treatment of the minor child.

The parent or authorized adult bringing in the minor child in responsible for any monies owed for copays, deductibles, and coinsurance or denied claims **at the time of visit**. We will be happy to let you know an **estimated** amount due for the visit at the time you schedule the appointment. Please be advised that the amount given is **only an estimate**. There may be additional fees charged that we are unaware of, or that insurance does not cover, etc. We are equipped to take these payments over the phone prior to the visit as an option.

It is not the responsibility of the physician and/or staff to communicate visit information to each custodial parent separately.

The providers and office staff of Serenity will not be put in the middle of domestic issues or disagreements. If we feel this is becoming an issue and compromising the care of the minor child/and or if at any time a family OR non-family member becomes abusive with the staff, we maintain our right to discharge the family from the care of the practice.

Only in situations where there is a **confirmed, documented Court Order** will one of the parent's be denied access to the minor child's health records or visits at the office. Serenity **must** have a copy of this Court Order on file in the minor child's electronic chart.

Stepparents, fiancés, girlfriends, boyfriends, or non-legal partners are not considered parents authorized to consent care without a **valid notarized letter signed by both custodial parents**.

I have read and agree to abide by the above policy.

_____

Child's Full Legal Name - PLEASE PRINT | Child's Date of Birth

_____

Custodial Parent Name - PLEASE PRINT | Custodial Parent Signature

_____

Custodial Parent Name – PLEASE PRINT | Custodial Parent Signature

_____

Today's Date

Authorization for Release of Health Information

Send Records To: Serenity Mental Health Centers
Mailing: 3300 N Triumph Blvd. Suite 500, Lehi, Utah 84043
Office: 480-630-4794 Fax: 480-210-0230
Email: info@serenitymentalhealthcenters.com

This form allows us to gather your history so we have a full picture of what you have tried which will help us give you the best level of care. Your doctor will be able to make a better treatment plan, and we will be better able to get insurance to cover your treatment options. **Please fill out one form for each doctor who has prescribed medication and/or any therapists.**

FOR:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

REQUEST RECORDS FROM:

Name of Provider or Facility: _____

Address: _____

Phone: _____ Fax: _____

Specific description of the information to be disclosed:

- ☐ Full medical record
- ☐ Medication Consent
- ☐ Psychiatric Evaluation
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Psychological Testing
- ☐ Phone contact
- ☐ Billing reports
- ☐ Lab Report
- ☐ Discharge Summary
- ☐ Demographics
- ☐ Mental Health-Substance Abuse
- ☐ Other:

Specific description of the purpose of the disclosure:

- ☐ Continued patient care
- ☐ Other (specify):
- ☐ Disclosure at patient request

By signing below, I authorize the provider to use or disclose information related to:
Behavioral Health care/Psychiatric Care, Insurance Coverage (COB), and I consent to the release of information created within 12 months before/after the date this authorization was signed

I understand my treatment is not conditional on signing this authorization. I may refuse to sign this authorization form. I may revoke this authorization at any time, unless the disclosing party has already relied on my authorization to disclose health information. To revoke my authorization, I must submit a written request to Serenity. If I do not revoke this authorization earlier, it will expire one year from the date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re- disclosed by the person/organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____

Signature of Patient/Legal Guardian Date

If you are not the patient, but are signing on behalf of the patient, please complete the following:

_____

Printed Name Relationship to patient (Legal guardian ONLY) Attach a copy of court documents if applicable

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

Introduction

At Serenity TMS Centers, LLC (Serenity), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective immediately and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record Information

Each time you visit Serenity, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

•Basis for planning your care and treatment

•Means of communication among the many health professionals who contribute to your care

•Legal document describing the care you received

•Means by which you or a third-party payer can verify that services billed were actually provided

•A tool in educating health professionals

•A source of data for medical research

•A source of information for public health officials charged with improving the health of this state and the nation

•A source of data for our planning and marketing

•A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of SERENITY, the information belongs to you. You have the right to:

•Obtain a paper copy of this notice of information practices upon request

•Inspect and copy your health record as provided for in 45 CFR 164.524

•Amend your health record as provided in 45 CFR 164.528

•Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528

•Request communications of your health information by alternative means or at alternative locations

•Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522

•Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

SERENITY is required to:

•Maintain the privacy of your health information

•Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

•Abide by the terms of this notice

•Notify you if we are unable to agree to a requested restriction

•Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We

will also discontinue use and disclosure of your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer or Office Manager.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family in an emergency: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES

FOR

Serenity TMS Centers, LLC

Patient Signature

Date

Patient Full Name:			Date of Birth:	Soc Sec #:
Mailing Address:			Home Phone:	Mobile Phone:
City:	State:	Zip Code:	Email:	
Gender:	Marital Status:		Ethnicity/Race:	Preferred Language:

Responsible Financial Party (mark self if over 18):	Date of Birth:	Soc Sec #:
Address:	Home Phone:	Mobile Phone:
Employer Name:	Employer Address:	

Primary Insurance			**Secondary Insurance**		
Insurance Name:			Insurance Name:		
Policy/Member ID #:			Policy/Member ID #:		
Group #:			Group #:		
Primary Subscriber Name:			Primary Subscriber Name:		
Date of Birth:	Soc Sec #		Date of Birth:	Soc Sec #	
Insurance PO Box Address:			Insurance PO Box Address:		
City:	State:	Zip:	City:	State:	Zip:

Emergency Contact Name:	Phone:	Relationship:

I authorize release of my personal information including medical treatment, scheduling and billing information to the individualslisted below. For the protection of my private health information, I understand that Serenity will ***not*** disclose information relatedto my personal health records to any individual not listed here. **Initial** _____

Full Name	**Relationship**

Primary Care Provider/Practice:	PCP Phone:
Please list any other doctors you are currently seeing(i.e. neurologist, internist, etc)	
Please list all current and past therapists' names and approx. dates of therapy:	
Preferred Pharmacy Name:	Pharmacy Address:

How did you hear about Serenity? (Check all that apply): ☐Search Engine (ex. Google) ☐Insurance ☐Friend/Family: _____ ☐Web Directory (Yelp, WebMD, Healthgrades, etc.) ☐Social Media (Facebook, Instagram, Twitter) ☐News Story ☐ Event ☐ Other:_____ ☐Referred by another provider: Name: _____ Phone: _____

Signature of Patient/Patient Representative **Date**