Payment Policy:

Payment in full is expected at time of service; including Copays, Co-Insurance, and Deductibles as assigned by your insurance. 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. Serenity makes every effort to collect accurate patient responsibility at time of service based on the information provided by your insurance carrier. Serenity expects prompt payment in full for services rendered. If you think your bill is incorrect, please call us at the number shown on your bill as soon as possible. If it is found that an incorrect amount was collected, and you are due a credit, Serenity will credit your patient account. If the amount of your credit is greater than $10.00, you may call the office to request a refund and Serenity will issue a refund check.

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, additional collection fees and your account will be forwarded to a collection agency. 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 by Serenity to your insurance at a later date.

If an account is turned over to an outside party for collection, the undersigned agrees to pay all costs of collection, including a service charge of 30% of all sums due plus reasonable attorney’s fees.

Cancellation/No-Show Policy:

Appointments at Serenity are in high demand and we value and respect everyone’s time including our doctors and staff and the valuable time of our patients. To that end, our policy is as follows:

Please cancel appointments at least 24 hours in advance.

Patients who are more than 10 minutes late to an appointment will be considered a no-show and must reschedule.

No-show and less than 24-hour advance notice cancellations will be charged a $40 fee. The fee will be waived if the patient is on time to the rescheduled appointment.

After 3 late cancelation or no-show appointments, Serenity will discharge the 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. All patients who are seen at Serenity must sign the following agreement:

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 whose signature appears below 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 do so 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. The pharmacy that I have selected is:
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. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please call during our regular business hours for refill requests.
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.

____________________________________  ______________________________________
Signature                                             Date

____________________________________
Print Name