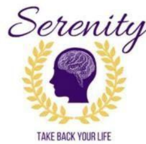


General Consent for Care and Treatment

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 similar ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

To make your patient experience better, Serenity TMS Centers, LLC, its affiliates, agents, and/or staff ("Serenity") prefers to communicate with the patient or patient's legally authorized representative regarding appointments, questions, and medications via patient portal, phone, and/or text; however, we do use email for some communication. If you wish to exchange information with Serenity via these electronic means, please be aware of the following: Email is not intended to replace regular communication with your provider. Emails may not be read or responded to immediately. Emails should go to info@serenitymentalhealthcenters.com and NOT to your provider directly. Your condition cannot be diagnosed or treated via email or other written communications. These electronic forms of communication may not be considered secure as they are not encrypted methods, so please be aware of the security risks and that others may inadvertently view them. You have the right to request and have your health care provider communicate with you by alternative means. If you prefer not to be contacted by electronic means, please email us at info@serenitymentalhealthcenters.com with the specifics of which electronic forms of communication you would like to opt out of, and if the request is reasonable and/or would not affect the provision of our healthcare services to you, we will opt you out of said form of communication.

If you do not want 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 recommended by your health care provider, we encourage you to ask questions. By signing below, I agree that I have been given the opportunity to ask any questions that I may have regarding my treatment. I understand that no guarantee has been made to me as to treatment results.

I consent to the taking of pictures for purposes of identification and treatment of my condition or disease, and the inclusion of such pictures in my medical record. In addition, I consent to the use of such pictures for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or descriptive texts accompanying the pictures.

I voluntarily request a physician, mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), other health care providers, and/or the designees to perform reasonable and necessary medical examination, testing and treatment for the condition, which has brought me to seek care at this practice.

I agree to abide by all Serenity policies, guidelines, and directives from Serenity staff, including but not limited to, agreeing to not audio and/or visual record Serenity and/or on Serenity premises.

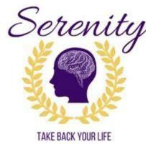
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

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

____

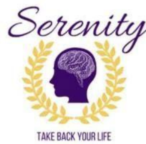
Printed Name of Patient or Legally Authorized Representative **Relationship to Patient**



Medication Agreement

Serenity is committed to doing all we can to treat your mental health. Medications, including controlled substances, are used as a therapeutic option in the management of anxiety states, insomnia, attention problems, and chronic pain. Controlled medications 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. In accepting medication from Serenity's providers, you agree to the following:

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, medical conditions, and/or of any adverse side effects I experience from any of the medications that I take.
3. All controlled substances must come from the physician at Serenity or, during his/her absence, by the covering provider, unless your Serenity provider agrees to and is aware of another provider's prescribing of a controlled substance. I understand that I must tell the provider whose signature appears on the script about all medications that I am taking, have purchased, or intend to take. 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 medications I am taking, and of the existence of this Agreement. In the event of an emergency, I will provide 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 understand that consuming alcohol or marijuana in conjunction with controlled substances is not recommended. 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 obtain or use any illicit drugs such as cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed psychiatric medication, or any combination of substances (e.g., alcohol and prescription drugs) could impair my driving ability, and may result in traffic violation and/or criminal charges.
9. Controlled medications or written prescriptions **will not** be replaced if they are lost, stolen, get wet, are destroyed, etc. **It is my responsibility to secure my medication in a safe manner. Initial** _______



10. ***Early refills of controlled meds will not be given.*** Renewals of medication are based upon keeping scheduled appointments. I understand I need to call during regular business hours for refill requests.
 Initial ________
11. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop. If Serenity cannot refill my meds due to my non-compliance, I understand I may need to seek emergency treatment to avoid withdrawals.
12. In the event that I am arrested or incarcerated, I understand refills on controlled substances will not be given.
13. I understand that my physician retains all authority and decision-making on when and how often to prescribe medication to me.
14. I understand that failure to adhere to the treatment plan outlined and/or these policies may result in cessation of therapy with controlled substances prescribed by this provider and/or discharge from the practice.

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 and discussed with my provider as consideration for, and as a condition of, the willingness of the physician whose signature appears on my records to consider prescribing or to continue prescribing medications to treat my mental health diagnoses.

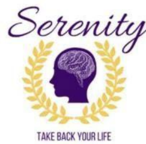
I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all its terms. A copy of this document can be given to me at my request.

____

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

____

Printed Name of Patient or Legally Authorized Representative **Relationship to Patient**



MISSED APPOINTMENT POLICY

It is our number one priority at Serenity 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 have cancellation lists of patients that would like to be seen as soon as possible and failure to notify us in time means we can't fill use that appointment time for a different patient. Please call and cancel your appointment **more than 1 business day (24 hours)** in advance to avoid a no-show fee. After-hours calls will be counted toward the next business day. The third no-show/cancellation of a provider visit will result in termination of care. By signing and dating below, I acknowledge and understand this policy at Serenity.

____

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

____

Printed Name of Patient or Legally Authorized Representative **Relationship to Patient**

Medication Refill Policy

Patients must have a follow-up appointment scheduled with their provider for refills to be sent. Patients must maintain good attendance to qualify for refills of medication.

I understand that refills can take up to 72 business hours to process and it is my responsibility to timely request a refill. Serenity will not be able to accommodate same day refill requests and will recommend emergency services if I need medication the same day. **Initial** ______

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

I understand that if I have no-showed, canceled, or rescheduled TWO (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, AND no refills will be sent until I am seen in person. **Initial**______

I understand that if I am discontinuing care with Serenity, no more than a 3-month supply of medications will be sent and will be subject to compliance with Serenity's medication policy. Additional refills after that will not be sent as it is my responsibility to establish care with a new provider. **Initial** ______

All early refill requests are subject to provider approval and good attendance. **Initial** ______

I understand that my provider is limited in their ability to send medication out of state and if I'm traveling or out of the state, my provider may not be able to send my prescriptions and I need to plan ahead. **Initial** ______

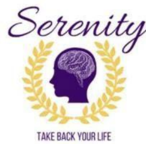
Patients can request *non-controlled* substance refills up to 7 days in advance. Refill requests on *controlled* substances can be sent to the pharmacy (2) days prior to the 30-day mark if no refills are on file and the pt is compliant with treatment plan and all policies. 90-day supplies will not be sent for insurance purposes unless the provider has sent out 30 days with 2 refills. If only a 30 day script was sent, medical necessity for the 30-day supply will be provided to the insurance to get coverage for medication. Medication refills will only be sent for active prescriptions. Any medications changes must be reviewed by your provider and will most likely require a return visit prior to sending.

____

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

____

Printed Name of Patient or Legally Authorized Representative **Relationship to Patient**



Guarantee of Payment and Assignment of Insurance Benefits

1. The patient promises to pay Serenity TMS Centers, LLC and/or its affiliates, agents, or assigns ("Serenity) for all charges incurred and to be incurred for services rendered and/or goods furnished.
2. Payment in full is expected at the time of service, including but not limited to, Copays, Co-Insurance, and Deductibles as assigned by your insurance.
3. The patient understands that although the patient and others may also be responsible for paying this account by virtue of an express or implied agreement or otherwise, the patient shall be responsible to pay the entire account and further understands that this agreement in no way relieves any such other party of any obligation to pay this account. Patient further understands that should this account become delinquent, and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, the patient shall pay the reasonable attorney fees or collection expenses.
4. 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.
5. Serenity 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 will credit your patient account unless requested otherwise.
6. 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.
7. 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 $65.00 and may be resubmitted electronically. Credit Card disputes will be subject to a service charge of $65.00. Continued issues with payment may result in discharge from the practice.
8. The undersigned hereby assigns any and all insurance benefits for services provided to Serenity and authorizes Serenity 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 to release any and all information necessary to perfect said insurance claim(s) and/or to collect any balance due to Serenity; 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.
9. 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 state or federal statutes.

I ACKNOWLEDGE THAT IT IS MY SOLE REPONSIBILITY TO DIRECTLY CONFIRM WITH MY PAYOR ANY AND ALL AMOUNTS THAT MAY BE DUE AND OWED BY ME RELATING TO ANY SERVICES SERENITY MAY PROVIDE TO ME.

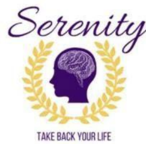
I further acknowledge that I understand and accept the terms herein and that the information that I have provided is accurate and correct.

____

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

____

Printed Name of Patient or Legally Authorized Representative **Relationship to Patient**



Serenity Parenting Policy

<u>We require an adult legally authorized representative to be present for the new patient appointment for children under 18. We require an adult legally authorized representative to be present for *every* appointment for patients under 16.</u>

We require a valid photo identification card of the adult legally authorized representative and a notarized statement indicating that any non-parentlegally authorized representative may consent to any and all treatment for that child. A **<u>valid photo ID</u>** includes any state issued ID card, valid state driver's license, military ID card, or valid government passport.

If an adult legally authorized representative 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 adult legally authorized representative bringing in the minor child is 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; however, 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 can take payments over the phone prior to the visit if needed.

It is not the responsibility of the physician and/or staff to communicate visit information to each legally authorized representative separately.

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

Only in situations where there is a **confirmed, documented Court Order** will one of the parents 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 to care without a **valid notarized letter signed by all legally authorized representatives of the patient or a court document with authorization**.

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

____

Child's ("Patient's) Full Legal Name - PLEASE PRINT | Child's Date of Birth

____

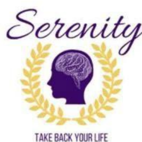
Legally Authorized Representative Name - PLEASE PRINT | Legally Authorized Representative Signature

____

Legally Authorized Representative Name - PLEASE PRINT | Legally Authorized Representative Signature

____

Today's Date



Authorization for Release of Health Information

Send Records To: Serenity TMS Centers, LLC at 3300 N Triumph Blvd. Suite 500, Lehi, Utah 84043

Office: 480-630-4794 Fax: 480-210-0230

Email: info@serenitymentalhealthcenters.com

To help us give you the best level of care, Serenity TMS Centers, its affiliates, agents, and/or assigns ("Serenity") is requesting that you fill out this form so that Serenity can gather your history and have a full picture of your past care. With this information, Serenity will have a better opportunity to make a holistic treatment plan, and we will be better able to contact insurance to discuss your treatment options. **Please fill out a separate form for each doctor and/or therapist who has prescribed medication.**

Patient Name: ____ Date of Birth: _________________

Address: ____

Phone: ________________________

AT THE REQUEST OF THE INDIVIDUAL PATIENT NAMED ABOVE, I AM REQUESTING THE BELOW ENTITY TO RELEASE THE FOLLOWING INFORMATION TO SERENITY:

Name of Provider or Facility: ____

Address: ____

Phone: _________________________________ Fax: ________________________

- ☐ **ENTIRE medical record, including but not limited to any of the categories listed in this section**
- ☐ Medication Consent
- ☐ Psychiatric Evaluation
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Psychological Testing
- ☐ Phone contact
- ☐ Billing reports
- ☐ Lab Report
- ☐ Discharge Summary
- ☐ Demographics
- ☐ Mental Health-Substance Abuse
- ☐ Other:

By signing below, I authorize Serenity to use or disclose my information, including any Behavioral Health care/Psychiatric Care and/or Insurance Coverage (COB related to my care), for Serenity's treatment, payment, and/or operational purposes.

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/Legally Authorized Representative Date

____

Printed Name of Patient/Legally Authorized Representative Relationship to patient (Attach court documents if applicable)

Serenity TMS Centers, LLC
3300 N Triumph Blvd. Suite 500, Lehi, Utah 84043
https://serenitymentalhealthcenters.com
Off-Site Privacy Officer Phone Number: (801) 823-1447
Privacy Officer Email Address: Legal@SerenityHealthcare.com

RECEIPT OF NOTICE OF PRIVACY PRACTICES

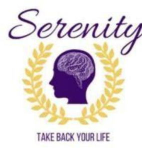
I hereby acknowledge that I have received Serenity TMS Centers, LLC and/or its affiliates ("Serenity's) Notice of Privacy Practices ("Notice"), which provides information about how Serenity may use and disclose protected health information about me. I understand that I have a right to request a copy of the current Notice and it will be available to me during the Registration process. I also understand that it is available through the Serenity website, https://serenitymentalhealthcenters.com. I acknowledge that I had the opportunity to review this Notice and have asked any questions that I may have. As provided in the Notice, the terms of the Notice may change, so it is recommended to always check the Serenity website.

____

Signature of Patient/Legally Authorized Representative Date

____

Printed Name of Patient/Legally Authorized Representative Relationship to patient (Attach court documents if applicable)



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:	
Emergency Contact - Name and Phone number:			Emergency Contact - Name and Phone number:	

Responsible Financial Party (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:

AUTHORIZATION TO RELEASE INFORMATION:

If there is someone who should be allowed to talk to us about billing, appts, medication or other treatment related details, please fill out the following:

I authorize release of my personal information including medical treatment, scheduling, and billing information to the individual(s)listed 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.

Name(s):

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 service:	
Preferred Pharmacy Name:	Pharmacy Address:

How did you hear about Serenity? (Check all that apply): ☐Google ☐Insurance ☐Friend/Family ☐Web Directory (Yelp, WebMD, Healthgrades, etc.) ☐Social Media (Facebook, Instagram, TikTok) ☐ TV ☐ Streaming (Hulu/Amazon Prime, etc… ☐Referred by Doctor: Practice Name____________________

Signature of Patient/Patient Representative **Date**