OFFICE POLICY

Appointments:
- ✓ Please be on time
- ✓ Cancel your appointment 24 hours prior to appointment time, if you are unable to attend, if you miss several appointments without reason, we may have to notify your physician or insurance company and you may be discharged
- ✓ Patients will be charged $25.00 for each cancelled and missed appointments.

Clothing and attire:
- ✓ Wear clothing attire appropriate for treatment (ie. Business shoes/attire to use gym equipment)
- ✓ No perfumes, strong body odors, or excessive scents
- ✓ It is appreciated if all patients wear clean clothes & have proper hygiene.

Safety:
- ✓ Children must be under adult supervision and are not to play with any equipment

Food and Drinks:
- ✓ No food or drinks are allowed beyond the waiting room area.

Lost or Stolen Items:
- ✓ We are not responsible for any items lost or stolen while attending our facility.

Reports/ Work Notes:
- ✓ A fee will be charged for reports and / or work notes
- ✓ Please see our receptionist for further details.

Work Injuries:
- ✓ If you are attending treatment as a result of a work injury, you must report your injury to the appropriate agencies.
- ✓ You are also responsible for providing our office with your claim number as soon as it is issued.

Private Insurance Coverage:
- ✓ Please contact your policy administrator for details for reimbursement.

Motor Vehicle Accident Injuries:
- ✓ If you are attending treatment as a result of a motor vehicle accident, you must provide our office with all the relevant information (claim number, adjustor name, etc.) for us to process your claim.

Billing and Payment:
- ✓ OPTION 1 - You to pay Serenity Health & Wellness directly for treatments received at the time of each visit.
- ✓ OPTION 2 - Serenity Health & Wellness will bill the insurance company / WCB directly.
    - You are responsible for any portion of the bill that the insurance company or WCB does not pay.
    - If the account is overdue by 3 months, you are responsible for the bill and will be reimbursed by the clinic if the insurance company pays.
    - As Serenity Health & Wellness may carry an outstanding patient balance for a period of time, a credit card in trust is required for security. Credit card slips will be returned or shredded upon request.
    - You will need to complete a Credit Card Billing Authorization form if you choose Option 2.
    - *It can take up to 3 months for insurance companies to inform the clinic of any treatments or portions of treatment not covered.*
- ✓ Please be aware that if your claim is denied, you are responsible for any and all charges accrued for your treatment at our facility.

Patient Signature

Date

Patient Consent Form

1) Consent to collect and disclose personal information.
Personal information that Serenity Health & Wellness collects, retains, uses, and discloses may include, without limitation, your name, age, contact information, health benefit information, occupation information, personal health information, medical history, and other information deemed necessary to fulfill the following purposes:

- To provide assessment and treatment services.
- To comply with the requirements of professional regulatory bodies, including file audits.
- To invoice you directly for services provided, and to process payment for those services.
- To provide information to Third Party Payers, Physicians and Legal Counsel already involved in your care
- To determine best clinical practices and ensure quality of service by the staff of Serenity Health & Wellness

I understand that Serenity Health & Wellness may use, share, disclose and retain my personal information, in order to fulfill the purposes noted above, or where otherwise permitted by law. I hereby give Serenity Health & Wellness permission and consent to maintain personal information on file. When requested, I herby give consent for information to be released as required unless specified in writing.

2) Consent to be contacted.
I give consent that I may be contacted at any of the phone numbers and/or mailing addresses provided to Serenity Health & Wellness. I give consent to Serenity Health & Wellness to leave messages at my contact number. In the case of a change in address
or telephone number, I give Serenity Health & Wellness consent to release information as needed so that I may be contacted.

3) Consent for payment.
I agree that in the event that I cannot attend my scheduled therapy appointment(s), that I will make every effort to notify and inform Serenity Health & Wellness at least 24 hours prior to my scheduled appointment. If I am unable to give appropriate notice of cancellation, I agree to pay a $ 25.00 missed or late therapy cancellation fee. Treatment may be suspended until the account has been paid in full.

I hereby give Serenity Health & Wellness my permission and consent for all of the above.

_____	_____	_____	_____
Patient signature	Date	Witness signature	Date