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 insurance company and you may be discharged.

Clothing and attire:

- Wear clothing attire appropriate for treatment.

Reports/ Work Notes:

- A fee will be charged for reports and / or work notes.

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:

- 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.

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.

______________________________ Patient Signature

______________________________ Date