Serenity
HEALTH SOLUTIONS

300 Rainbow Drive
Suite 102
Florence, SC 29501
Voice 843-942-9960
Fax 802-400-2609
www.serenityhealthcaresolutions.com

# Patient Information

Name_____ Preferred Name_____

Date of Birth_____ Sex_____ Social Security#_____

Contact Information

Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell_____ Work Phone_____

Email Address_____ Preferred Method of Communication_____

Would you like to enroll in our Patient Portal? _____

Who was your most recent primary care provider? _____

Do you see any specialists? _____

Are any of your immediate family seen at this practice? _____

Were you referred here by someone? _____

Emergency Contact

Name_____ Relationship:_____

Phone_____Address_____

City_____ State_____ Zip_____

Next of Kin (if Different than Emergency Contact)

Name:_____ Relationship:_____

Phone:_____Address:_____

City:_____ State:_____ Zip: _____

Marital Status: (Single) (Married) (Divorced) (Widowed) (Separated) (N/A)

Spouse Name:_____ DOB___/____/_____

Phone# (____)_____

## Payment Information

**We will make a copy of your card, please supply needs information for medication and testing authorizations.**

Employer Name_____

Primary Insurance Name:_____ Policy Number:_____

Secondary Insurance Name:_____ Policy Number:_____

Primary Insured if different: _____

SS#: _____ DOB:____/_____/_____

Your relationship to primary insured: (Spouse) (Child) (Other)

**If completed by other than the patient, please complete this section**

Name_____ Social Security #_____

Phone_____ Date of Birth_____

Address:_____ City_____ State_____ Zip _____

Relationship to patient:_____

Even if Self Pay: Please sign below in acknowledgement of payment type for services rendered.

Signature:_____ Date:_____

Print Name:_____

# Medical History

**Please list any allergies to medications or food?**

**Please list any medications and supplements you are currently taking**

**What pharmacy do you use?**_____

Do you or an immediate family member suffer from any of the following?

| | Self | Family | | Self | Family |
|---|---|---|---|---|---|
| Skin Problems | | | Diabetes | | |
| Asthma | | | Cancer | | |
| Lung issues | | | Hypertension | | |
| Heart Condition | | | Head/Spinal Issues | | |
| Hepatitis | | | Broken Bones | | |
| Hearing or Vision Problems | | | HIV | | |
| Back Problems | | | Muscular Disease | | |
| Varicose Veins | | | Seizures, Fainting | | |
| Mental Illness | | | Depression Anxiety | | |
| Chronic Fatigue | | | Arthritis | | |
| History of Substance Abuse | | | Auto Immune illness | | |

**Surgical History**

**Do You Drink alcohol?** Yes / No **If Yes, how much do you drink?**

**Do you smoke, or have you ever smoked?** Yes / No

If yes, how many years have you or did you smoke and how many packs per day?

# Patient Consent for Treatment, Services and Payment

**Consent for Treatment and Services:** I hereby give my consent for treatment and related services considered necessary by Serenity Health Solutions for the patient whose name appears below who is seeking or is under the care of the applicable Serenity Health Solutions provider, his/her associated, assistants, employees or designees. I hereby understand that such treatment, may include, but is not limited to, necessary examination and/or assessments, laboratory, diagnostic and/or medical care and procedures, prescribed medical information, if available; and/or recordings and/or filming for internal purposes, which the Serenity Health Solutions provider, his/her associates, assistants, or designees may be deem necessary or advisable. I hereby authorize Serenity Health Solutions, its agents and/or employees to make recording of my voice, image, or likeness in media whatsoever, including but not limited to photographs, videotapes, audiotapes, or any electronic or digital medium. I understand that recordings may be used for research, diagnostic, therapeutic, educational or publication relations purposes. I further understand that I have the right to withdraw my consent to a recording being made at any time before the recording is made and for the use of such recording within a reasonable period of time before the recording is used for any of the permissible purposes.

**Payment of Services:**.I hereby understand that Serenity Health Solutions is a **Cash Service Facility only**. I understand fully that Serenity Health Solutions **does not accept any type of insurance plans for healthcare services**, and **I must pay in full at time services are rendered.** I understand that I am financially responsible to Serenity Health Solutions and providers of service for charges incurred. I understand that should the account be referred to an attorney for collection, I shall pay all reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I further agree that in the event medical benefits exceed charges for services in connection with this episode of care, that such excess amount be first applied to the payment of any other indebtedness due by me for treatment and services rendered or any for amount for which I am responsible on account of other episodes of care of services received from Serenity Health Solutions, and the balance, if any remains, to be paid to me. I further agree that Serenity Health Solutions is authorized to act on my behalf in the endorsement of benefit checks made payable to me and/or Serenity Health Solutions. If I am a participant/beneficiary of an employee welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), I designate Serenity Health Solutions as my authorized representative and grant to Serenity Health Solutions to act on my behalf in pursuing and appealing a benefit determined under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary plan description. Certain laboratory services are processed and billed by outside laboratory companies. Therefore, you will receive separate billing from these companies for services rendered.

**Disability/FMLA/Leave of Absence** forms could incur a minimum charge of $20 for completion. This fee would be collected prior to the completion of the document requested. Documents would be prepared within 10 business days upon request. Some cases may require an office visit.

**Payment Guarantee:** I hereby jointly and severally agree to pay all charges for services received by the patient named below during this "episode of care" and/or subsequent visits. Acceptable payments are credit cards and cash. Unpaid balances over 90 days may be subject to collections.

**Follow-up/New Episodes of Care:** I understand that the patient named below may come in for subsequent care following his/her initial visit to Serenity Health Solutions. I understand that the patient named below may receive subsequent care and/or treatment related to such episodes of care. I hereby acknowledge that I/he/she will not be required to complete a subsequent registration form containing all of the information stated within this Patient Consent for Treatment, Services and Payment but agree to be bound by the terms and conditions herein. I have read the above Patient Consent for Treatment, Services and Payment, have had the opportunity for clarifications and understand the same and certify that no guarantee or assurance has been made as to the results that may be obtained as related to such treatment and services.

**No Call/No Show/Late Cancellation Fee:** I hereby jointly and severally agree to pay the fee of $25.00 per incident that takes place in addition to cumulative cost of next follow up visit. I understand that outstanding balances may affect future servicers until the balance is resolved.

Patient or Authorized Representative Signature:_____ Date:_____

Print Name:_____Relationship:_____ Witness:_____

**Designation of Caregivers for Communication of Protected Health Information**

**For the following patient:**

Patient Name:_____ Date of Birth: _____

At my request, I authorize the person(s) listed below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this person(s) may inquire about the appointment on my behalf.

_____

Name Relationship DOB Phone

_____

Name Relationship DOB Phone

_____

Name Relationship DOB Phone

OR

_____(initial) I do not want any of my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize Serenity Health Solutions to communicate my protected health information to me via the following methods:

□ Leave detailed message on my answering service Phone: (_____)_____

□ Leave message with a call back number only

□ Leave detailed message on my work voicemail Phone: (_____)_____

□ Ok to mail my home address

□ Ok to mail my work address

□ Email/Fax detailed medical information (email:_____/fax:_____)

I understand that my health care provider will use judgment in determining the minimum amount of information that must be shared in order to care for me. Serenity Health Solutions will make a diligent good faith effort to determine the identity of the requestor before the release of my personal health and/or billing information by verifying the address, date of birth and phone number for the authorized representatives I have designated. Serenity Health Solutions is not liable for any misuse of my personal health or billing information by the representative(s) authorized (listed) above. I understand this authorization will remain in effect unless otherwise notified and/or revoked.

Serenity Health Solutions Medical is operated by a Nurse Practitioner. In the state of South Carolina, Nurse Practitioners can operate without the direct supervision of a medical doctor. The nurse practitioner is solely responsible for the diagnosis and treatment you will receive. Becoming a patient of Serenity Health Solutions Medical establishes a provider/patient relationship with the nurse practitioner and does not establish a relationship with any doctor or specialist. Should your condition fall outside the nurse practitioner's scope of practice, you will be referred to an appropriate specialist. Serenity Health Solutions Medical is not in operation connected with or affiliated with any other physician, clinic or medical group.

**Privacy Pledge**

I hereby acknowledge that I have been offered a paper copy of the Notice of Privacy Practices, which sets forth the manner in which the protected health information of the patient name below may be used or disclosed by Serenity Health Solutions and outlines applicable rights with respect to such information. I also acknowledge that I have been allowed to ask questions related to the Notice of Privacy Practices. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf as indicated below.

Patient or (Authorized Representative)

Signature _____ Relationship:_____ Date:_____

Print Name:_____ Witness:_____

# Important Notice

Serenity Health Care Solutions is a **Nurse Practitioner** owned clinic. In the State of South Carolina Nurse Practitioners are allowed to operate without the direct supervision of a medical doctor. The Nurse Practitioner is solely responsible for the diagnosis and treatment you will receive. Becoming a patient of Serenity Health Care establishes a provider/patient relationship with the nurse practitioner and does **not** establish a relationship with ANY doctor or specialist. Should your particular issues fall outside of the Nurse Practitioner's scope of practice you will be referred to an appropriate specialist. Serenity Health Care is not operated in connection with, or affiliated with any other physician, clinic, or medical group.

**Consent of Treatment**

I understand that by signing this form, I give consent to receive treatment by one and/ or all of the Healthcare Practitioners working in the Serenity Health Care Solutions facility.

I Acknowledge that I have received the Notice of Privacy Practices.

**Please acknowledge understanding of this by signing below:**

Signature of Patient or Representative: _____ Date: _____

Print of Patient or Representative:_____

Relationship to Patient:_____

Signature of Provider: _____ Date: _____

Witness: _____ Date: _____

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# Informed Consent for Telemedicine Services

## INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow?up and/or education, and may include any of the following:

*Patient medical records
*Medical images
*Live two-way audio and video
*Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

## EXPECTED BENEFITS

*Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
*More efficient medical evaluation and management.
*Obtaining expertise of a distant specialist.

## POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

*In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
*Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
*In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
*In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

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***BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:***

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,

3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a ***reasonable fee***,

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. (*name of Physician*) has explained the alternatives to my satisfaction,

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform (*name of Physician*) of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

8. **I understand that I am financially responsible for all charges for services rendered through electronic communication that falls under (*name of Physician*) providing services such as, but not limited to telephone calls, emails, text messages, video conferencing, prescription renews, etc.**

## PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize (*name of Physician*) to use telemedicine in the course of my diagnosis and treatment.

| Patient Signature ( or Authorized Representative) | Relationship | Date |
|---|---|---|
| Print Patient Name ( or Authorized Representative) | | Witness |

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Credit Card Authorization Form / Save Card on File

The undersigned agrees and authorizes Max Primary Care to save the credit card(s) indicated below on file. The use of this form is optional and for your convenience.

Name on Card:_____
Card Type:_____
Last 4 Digits: _____
Card Expiration:_____
Billing Zip of Card:_____

I authorize Max Primary Care to process the above credit card as "Card on File" and charge in accordance with the agreed upon payment plan between the practice and me (e.g. one time charge, monthly payment plan, etc). I understand this authorization will remain in effect until the expiration of the credit card account. Patients may also revoke this form by submitting a written request to the medical practice.

Signature of Patient:_____ Date:_____
Print:_____

## Reminders:

1. *If the card is not in the Patient's name, we must have an Authorization Form completed by the owner of the card in order to save it on file and to process the card for transactions.*

2. *Each card that is placed on file has to have an Authorization Form.*

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# Schedule 2,3,4 Controlled Substances Treatment Agreement

As a patient of Serenity Health receiving schedule 2 or MAT medications I agree to the following:

1. To keep all my scheduled appointments or change the appointment in advance, except in the case of an emergency. _____
2. I agree not to sell, share, or give any of my medication to another person. ____
3. I agree not to deal or sell drugs at Serenity Health, or in its parking lots or property._____
4. I agree that my medication/prescription will only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit. _____
5. I agree that the medication I receive is my responsibility and I agree to keep it safe and secure. I agree that lost/stolen medication will not be replaced regardless of why it was lost or stolen. _____
6. I agree not to obtain controlled substances for example opioids and benzodiazepines, from any other healthcare providers, pharmacies, or other sources without telling my treating physician. _____
7. I understand that mixing controlled substances with other medication's, especially benzodiazepines and opioids can be dangerous. I understand deaths have occurred among persons mixing opioids and benzodiazepines. There is also a risk of overdose death for mixing Opioids with large amounts of alcohol or other types of sedatives, such as barbiturates _____
8. I agree to provide random urine samples for drug testing and have my healthcare provider test my alcohol level whenever I am asked to do so. _____
9. (MAT) I agree that my goal is to stop using addictive drugs, and that I will work to stop using all addictive and illegal drugs during my treatment with Buprenorphine. _____
10. I agree that violating this agreement may result in my no longer receiving treatment at Serenity Health. _____
11. I understand that if I decrease my use of opioids or substitute Buprenorphine for these drugs, I have a higher risk of dying from an overdose. I understand that if I relapse, I need to use small doses of opioids until I learn what my body can tolerate _____
12. I understand that Buprenorphine, opiates, and benzodiazepines are extremely dangerous for infants and children. They can stop breathing after taking tiny amounts of this medication. I agree to keep my supply of this medication locked securely away from others, especially infants and children. _____

Patient Name

Print:_____Sign:_____DOB:_____

Witness:_____ Date:_____

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# NOTICE OF PRIVACY PRACTICES

This notice describes how health care information about you may be used and disclosed and how you can get access to said information. PLEASE REVIEW CAREFULLY

We are committed to protect the privacy of your personal health information. This notice of privacy practices describes how we may use within our practice or network and disclose (to share outside of our practice or network) your protected health information (PHI) to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This notice also described your rights to access and control your PHI. We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this notice.

We may change our notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised notice by:

- Posting new notice in our office
- If requested, copy may be acquired by mail
- Revisions posted on our website

Uses and Disclosures of Protected Health Information

We may use or disclose your PHI to provide health care treatment for you. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Ex: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that your physician has the necessary information to diagnose or treat you. We may also share your PHI to another physician or health care provider (i.e.: specialist/laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. We may also share your PHI with people outside of our practice that may provide medical care for you, such as home health agencies.

Your PHI may be used to obtain payment services. There may be services for which we share information with your health plan to determine if services will be paid. Your PHI will be shared with, but not necessarily limited to the following:

- Billing companies
- Insurance companies, health plans
- Government agencies to assist with qualification of benefits
- Collection agencies

Ex: You are seen in our office for a specific procedure. Those services are shared with your insurance company for reimbursement. We may contact your health plan to receive approval prior to preforming certain procedures to ensure coverage.

Your PHI may be shared to support the business activities of this practice which are called health care operations. i.e.:

- Training students, other providers, or ancillary staff
- Quality improvement processes which look at delivery of health care and for improvement is processes which will provide safer, more effective care for you
- To assist in resolving problems or complaints within the practice

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Your PHI may be use without your permission in the following situations:

- If required by law: The use and disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding, or other lawful purposes
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release
- Coroners, funeral directors: We may disclose PHI to a coroner or medical examiner to perform other duties authorized by law
- Medical research: May disclose PHI to researches when their research has been approved by an institutional review board that has reviewed research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law, which is necessary for your health or the health and safety of other individuals.
- Worker's compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Other uses and disclosures of your PHI

- Business associates: some services are provided using contracted entities called "business associates" (BA). We will always release only the minimum amount of PHI necessary so that the BA can perform the identified services. We require the BA to appropriately safeguard your information. Examples of a BA include billing companies or transcription services.
- Health information exchange: We may make your PHI available electronically to other healthcare providers outside of our facility who are involved in your care.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health
  Appointment reminders: We may contact you as a reminder about upcoming appointments or treatments.

We may use or disclose your PHI in the following situations unless you object:

- Share your PHI with friends/family members or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. Ex: We may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that responsible for your care of your location, general condition or death.
- To an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Release of psychotherapy

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Privacy Rights
You have certain rights related to your PHI. You have the right to see and obtain a copy of your PHI. We may charge you a reasonable fee for records request. You have the right to a list of people or organizations who have received your health information from us. If your request for records of periods longer than 12 months, but within the appropriate legal timeframe, you may be charged a reasonable fee.

Additional Privacy Rights:
You have the right to obtain paper copy of this notice, upon request. You will receive a copy of this policy on your initial visit to our office. You have the right to receive notification of any breach of your PHI.

Complaints
If you think we have violated your rights, or have a complaint you may contact the privacy officer of Serenity Health Care Solutions by mail to 300 Rainbow Drive Suite 102, Florence, SC 29501 or by phone: 843-942-9960. You may also list a complaint to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated.