



Serenity Wellness LLP
15 Hosley Avenue
Branford, CT 06405
P: 860-975-7455
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Welcome to Serenity Wellness. We are a small private practice dedicated to providing mental health services to our clients.

We do not have an on-call service. If a patient contacts us after 4:00 p.m. Monday through Friday the message may not be received and returned until the next business day. If there is an emergency or urgent issue patients and families are advised to call 211 (mobile crisis) or 911.

We will not make medication adjustments or initiations over the phone/e-mail/text.

- If you have paperwork that needs to be filled out we require a minimum of three business days to complete it. There may be a fee of 50.00 associated with paperwork and/or you may be required to come for an appointment to have it filled out.
- Serenity Wellness provides psychiatric services in the form of psychotherapy and/or medication management. By making an appointment and becoming a patient of this practice you are consenting to treatment with psychotherapy and/or medication management.
- Patients are expected to conduct themselves appropriately while in the office and waiting room, and also on the phone and via e-mail. **Patients exhibiting hostility, verbal aggression, or threatening statements may be immediately discharged from the practice.**
- If a patient does not call to cancel or reschedule an appointment and the patient does not show up to the scheduled appointment this is considered a missed appointment and there is a fee of 75.00 for each missed appointment.
- We require 48 hours notice to cancel any appointment otherwise there is a fee of \$75.00 that will be charged. If an appointment is canceled 24 hours or less before your scheduled time then a fee will be charged of 75.00.
- Please note Saturday appointments are popular and book quickly. If you no-show or late cancel a Saturday appointment the patient is responsible for a fee of \$100.00.
- If there is snow or inclement weather the office will call with notice of cancellation.

- We utilize an automated system which stores patient's credit cards. The system is HIPPA compliant. We will use these cards for co-pays and deductible payments and missed appointment fees only. If you have a missed appointment fee accrue your card will be charged for \$75.00. **All clients are required to maintain a credit card on file.**
- If the patient's insurance carrier refuses payment the patient will be notified and we will work together to try and rectify the problem. However, if ultimately the insurance company refuses to pay for services already rendered then the patient is responsible for payment of past services.
- If a balance accrues and clients do not make payments then after ninety days we reserve the right to send your account to a collections agency.
- We utilize email and text message on a designated business line. However texting and e-mailing is never 100% HIPPA compliant. Please do not send protected health information via text or e-mail, and if you do you are consenting to do so over a non-HIPPA compliant connection. We strongly encourage you to utilize the patient portal through our medical record system to send messages and refills requests to your providers. **Refill requests sent by text or email may not be fulfilled.** You may also contact your pharmacy directly and they will send an electronic refill request.
- We encourage people to be in charge of their healthcare and treatment. If you are unhappy about any experience you have at Serenity Wellness please contact us directly so we may address your concerns.

I have read the above policies and consent to treatment at Serenity Wellness and by signing below I acknowledge that I have read and agree to abide by the above policies.

Patient or Guardian

Date

Authorization to Release Information to Health Insurance Entities

If you would like to utilize your healthcare insurance, please note it may be necessary to release information to the insurance company regarding diagnosis and treatment.

Please sign the statement below authorizing release of information to your insurance carrier:

I authorize Serenity Wellness to communicate pertinent and confidential information with _____ (Insurance Carrier)

regarding the psychiatric consultation, and treatment of

_____ (Patient).

I authorize Serenity Wellness to submit claims to my insurance carrier electronically.

Patient or guardian

Date

Serenity Wellness

Patient's Legal Name: _____

Patient's Legal Gender: _____

Patient's Gender Identification: _____

Date of Birth: _____

Emergency Contact Name: _____

Cell Phone Numbers: _____

Email Address:

Home Address: _____

Insurance Company: Anthem Cigna Aetna Magellan

Insurance ID Number: _____

Insurance Group Number: _____

Carrier of Insurance (self/partner/parent): _____

Insurance Carrier's date of birth: _____

Insurance Carrier's Address: _____

Is there a Secondary Insurance? _____

Co-pay or deductible: _____

Serenity Wellness
Privacy Practices

- You may request a copy of your medical record and other health information we have about you at any time. You would need to sign a Serenity Wellness release of information and specify how and who we are releasing your medical record to.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. If you request a summary of treatment or anything other than a copy of your electronic medical record then we may charge a fee of \$50.00.
- We are mandated reporters therefore any report of physical, sexual, emotional abuse may have to be reported to the state and to the parents or guardians.
- If any one discloses suicidal intent or homicidal intent we are mandated to take action as well, and we may have to break confidentiality and privacy in order to abide by the law.
- At Serenity Wellness we will do everything possible to protect your privacy and follow the laws set forth by state and federal government. We will only share protected health information while following the laws set forth by our state and federal government agencies.

I have received a copy of and understand the privacy practices of Serenity Wellness.

Patient/Guardian

Date

Telehealth Consent
Serenity Wellness LLP
15 Hosley Ave
Branford, CT 06405

By signing below _____ consents to receive mental health treatment in the form of psychotherapy and/or medication management by Serenity Wellness LLP via telehealth platform. I understand I will receive an "invite" and can dial in from my smartphone or from a computer. I understand the appointment may only proceed if video and chat feature are available and working. Chat only telehealth is NOT covered by insurance plans. Video must be utilized. I understand that I may be asked for a recent weight and height and I will have that information available for my provider. I understand that telehealth may not be recommended by my provider by the end of our session and I may have to go to the office for our next scheduled appointment.

By signing this form I am consenting to telehealth with my mental health provider via a HIPAA compliant platform that utilizes video and chat.

By signing this form I am confirming and attesting that I am located within the state of Connecticut at the time of service as my provider is only licensed in the state of Connecticut.

This form is good for one year unless otherwise specified.

Signature

Date

Past Medical History(asthma, hypertension, etc.):

Past Surgical History (Surgery & Date):

Past Medical and/or Psychiatric Hospitalizations (Date and place):

Current Medications (Name/Dose/Times a day):

Past Medications (Names, doses, adverse effects, why they were discontinued):

Release of Information Serenity Wellness

I _____ grant permission for
_____ to obtain the following from
Serenity Wellness.

I _____ grant permission for
_____ to disclose the following to
Serenity Wellness.

- Psychiatric record in the form of a treatment summary
- Psychiatric record including Progress and Admission notes
- Substance Abuse record
- HIV/Hepatitis test results
- Medical record
- Diagnosis and treatment plan
- Appointment history

Patient/Guardian Signature

Date