Serenity Now Psychiatric & Counseling Services

(A Division of Hoosier Uplands Economic Development Corporation)
2125 16th St. • Bedford, IN 47421
(812) 275-4053 • Fax (812) 275-5494

Enclosed you will find our new client information packet. Please complete all forms and return them to Serenity Now. Once we receive your completed packet with a copy of your insurance card, your information will be reviewed by our Clinical team to determine if we can appropriately serve your needs. Serenity Now is an independent psychiatric and counseling clinic which provides specialized services. When our ongoing clients are interested in psychiatric medication management, we work on a team philosophy in which clients receiving medications are also actively engaged in therapy with our staff at Serenity Now. At this time we are unable to see children under the age of 12 for medication management.

FIRST APPOINTMENT: Coming in for treatment for the first time to a new location can be intimidating for some. You will be meeting with one of our therapists on your first appointment to complete your initial evaluation. If appropriate, the therapist will make arrangements for you to be scheduled with one of our prescribers for medications at a later date. *You will not be prescribed medication on your initial evaluation at Serenity Now.*

If the client is a minor (under the age of 18) the legal guardian (parent, case worker or state appointed guardian) MUST BE PRESENT FOR THE INITIAL APPOINTMENT. If there is a custody arrangement, make sure to bring a copy of the custody papers.

If you have any mental health records, school records or psychological testing within the last five years, please obtain a copy and have them sent to our office. In order to provide the best mental health services it is crucial to obtain as much background information as possible. Please complete any needed Releases of Information so we may contact your referring resource.

ATTENDANCE: We have a strict policy in place on attendance. It is the policy of Serenity Now that failure to attend a scheduled appointment or failure to cancel a scheduled appointment more than 24 hours in advance, may result in a $50 fee. This fee will need to be paid prior to your next appointment. Three no-shows or late cancellations within a 6 month period will result in termination of services. If you miss your initial appointment we will not reschedule.

Thank you for considering us for your mental health needs.

Serenity Now Psychiatric and Counseling Services

Serenity Now Patient Demographic Sheet

Name: _____ Date of Birth: _____
First Middle Last

Address: Social Security Number: _____

_____

City/State/Zip: Primary Phone: _____

_____

Sex: Male / Female Status: Single / Married / Widowed / Divorced

Email address: _____

Is this visit covered by your Employee Assistance Program (EAP): Y / N Authorization Number: _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Primary Insurance

Company:_____ Policy Number:_____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Address: _____ Policy Holder SS#: _____

City/State/Zip: _____ Relationship to Patient: _____

Secondary Insurance

Company:_____ Policy Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Address: _____ Policy Holder SS#:_____

City/State/Zip: Relationship to Patient: _____

_____

Financial Responsibility

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

City/State/Zip: _____ Employer:_____

Coordination of Benefits

Primary Care Doctor: Phone Number:

_____ _____

I give permission to Serenity Now Psychiatric and Counseling Services to contact my primary care provider to inform them that I am seeking treatment. This information will be limited to the Coordination of Benefits guidelines and will not include personal information disclosed during treatment without a Release of Information signed by myself/guardian/representative.

Signature: Date:

_____ _____

Note: If client is a minor or under guardianship, parent/guardian must sign

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CLIENT SELF-ASSESSMENT

The following questions will help us to know you and help in the planning of your care. Please answer all questions to the best of your ability. All information received is confidential. Questions notated as "optional" may be left blank if you do not wish to answer.
All applications and evaluations will be reviewed by administration and medical staff prior to final acceptance.

Name_____ Age_____ Date of Birth___/___/___
Preferred Pronouns: _____

If Child: Parents'/Legal Guardians' Names:_____
Phone Numbers: _____
Are parents divorced?: _____ Custody status: _____
Who does child live with?: _____
A biological parent or legal guardian must attend the first therapy appointment and all medication appointments ***We require copies of custody papers before scheduling appointment.***

Who referred you here?_____Today's Date ___/___/___

Presenting Problem and History of Present Illness:
Please tell us about the events that brought you here today:

_____

_____

_____

_____

When did the problem / symptoms start?: _____

Was there anything that happened to bring on the problem or make it worse?:_____

_____

What have you tried to help the problem?:_____

Are you currently in treatment?: ☐Yes ☐No With whom?_____

What services are you seeking?:
(Please be aware that therapy is a requirement of treatment)
☐ Individual Therapy ☐ Medication ☐ Family Therapy ☐ Group Therapy

If currently in treatment elsewhere, why are you wanting to seek services with us?:

_____

Past Psychiatric Treatment:
Have you had counseling for this problem? If yes, when, with whom, and was it helpful?:

Have you taken medication for this problem? If yes, what, when, who prescribed it, and was it helpful?:_____

Please check if you are having problems with any of these:

☐ Anger	☐ Appetite	☐Concentration	☐ Energy
☐ Hallucinations	☐ Mood	☐ Relationships	☐ Sleep
☐ Thinking	☐ Thoughts of hurting Self		☐ Thoughts of hurting others

Medical History:
Illnesses: Please check any of the following that you have, or have had in the past.
Respiratory problems: ☐ Asthma ☐ Infectious Disease
Cardiovascular problems: ☐ Heart Murmur ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Anemia ☐ Heart Attack ☐ Bypass Surgery
Neurological problems: ☐ Seizures ☐ Stroke ☐ Headaches ☐ Blackouts ☐ Head Injury With Loss of Consciousness ☐ Head Injury Without Loss of Consciousness ☐ Neuropathy
Endocrine problems: ☐ Diabetes ☐ Thyroid
Gastrointestinal problems: ☐ Reflux ☐ Gastritis/Ulcers ☐ Hepatitis
Weight change: ☐ Loss ☐ Gain Amount:_____ Length of time:_____
Musculoskeletal problems: ☐ Arthritis ☐ Fractures ☐ Sprains ☐ Back Pain ☐ Physical Limitations ☐ Degenerative Disk
Skin problems: ☐ Skin Problems ☐ Rash ☐ New Tattoo ☐ Burns ☐ Cuts ☐ Scars
Sleep problems: ☐ Sleep Apnea ☐ Restless Legs ☐ Snoring ☐ Daytime Fatigue ☐ Insomnia ☐ Problem Falling Asleep ☐ Interrupted Sleep
Hospitalizations: _____
Surgeries: _____

Are you experiencing any type of current or chronic pain?: ☐ Yes ☐ No
If Yes, Location?_____
How often does it occur?:_____ How long does it last?: _____
What relieves your pain?:_____
What makes your pain worse?: _____
Are you under pain management?: ☐ Yes ☐No
If yes, with whom?: _____
Allergies:_____
Reactions:_____

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Who are your **Primary and/or Treating Doctor(s):** _____

Current Medications: (include over the counter medications and nutritional supplements):

NAME	DOSAGE	HOW OFTEN	HOW LONG HAVE YOU TAKEN	PRESCRIBED BY

Substance Use:

Substance Type	**Current Use**	**Past Use**
	Check All That Apply:	Check All That Apply:
Caffeine		
Tobacco/Cigarettes		
Over-the-Counter		
Alcohol		
Marijuana		
Heroin/Opiates		
Methamphetamine		
Sedatives		
Cocaine/Crack		
Hallucinogens		
Other_____		

Family History:

Please note if anyone in your family has had any of the following problems:

PROBLEMS:	**WHO HAD PROBLEM:**	**PROBLEMS:**	**WHO HAD PROBLEM:**
Anxiety		Blood Pressure	
Bipolar Disorder		Cancer	
Criminal Behavior		Diabetes	
Depression		Heart Attack	
Mental Illness Unknown		Seizure	
Schizophrenia		Stroke	
Substance Abuse		Thyroid troubles	
Suicide		Other	

Social History:
I was told I had the following problems in early growth or development:
☐ None ☐ Learning to walk ☐ Learning to talk ☐ Major childhood illness
☐ Problems in relationships with others ☐ Other (please explain)_____

I have been a victim of violence and/or abuse:
☐ None ☐ Childhood physical abuse ☐Childhood sexual abuse ☐ Childhood emotional abuse
☐ Rape ☐ Spouse abuse ☐ Other (please explain)_____

Education:
☐ Current grade in school:_____ ☐ I did not finish high school ☐ I graduated high school
☐ G.E.D. ☐I completed some college ☐I have a college/graduate degree in_____

Relationship Status:
I am:☐ Single ☐ Married ☐ Separated from spouse ☐ Widowed ☐ Divorced ☐ In a relationship

My sexual orientation is (optional): ☐ Heterosexual ☐ Homosexual ☐ Bisexual
☐ Another orientation: _____

My gender identity is (optional): ☐ Female ☐ Male ☐ Nonbinary
☐ Transgender Female (M to F) ☐ Transgender Male (F to M)
☐ I have concern about my gender identity ☐ Another Identity: _____

I am currently living: ☐ Alone ☐ With spouse ☐ With parents ☐ With children ☐ With partner ☐ With friends/roommates ☐Other (please specify)_____

Employment Status:
I am currently: ☐ Working as a _____
☐ Home maker ☐ Unemployed ☐ Disabled ☐ Student ☐ Retired
I have been fired or asked to resign from my job(s) in the past ☐Yes ☐No
Please explain:_____

I have/had legal problems in the past or present (criminal or civil) ☐Yes ☐No
Please explain: _____

I have contact with a Social Agency (Welfare, Social Security, Community Services) to get help for my family or myself: ☐Yes ☐No
Please explain:_____

Language (optional)
My preferred language is: ☐ English ☐ Other (please specify) _____

Race (optional)
I am: ☐ white ☐ black or African American ☐ Asian ☐ Native American or Native Alaskan
☐ Native Hawaiian or Pacific Islander ☐ multi-racial

Ethnicity (optional)
I am: ☐ not Hispanic/Latino ☐ Hispanic/Latino

Military Status: ☐None ☐Veteran ☐Presently in the military
Number of years/months served:_____ Type of discharge:_____
☐ Service connected disability (please explain)_____

Are there any questions on this form that you did not answer because you did not feel comfortable answering? ☐Yes ☐No

Serenity Now Psychiatric & Counseling Services **CONDITION OF SERVICES**

A Division of Hoosier Uplands Economic Development Corporation

1. I, the undersigned, hereby consent to and authorize the administration and performance of all treatment, and healthcare operations that, in the judgment of my physician/healthcare providers, may be considered necessary or advisable. This includes in person, telehealth, telemedicine, and telephonic services.
   I further consent to and authorize Serenity Now Psychiatric & Counseling Services, a Division of Hoosier Uplands Economic Development Corporation (hereinafter referred to as Serenity Now) to furnish or release to any insurance company, worker's compensation board, self-insured organization, mutual hospital associations and/or other covered entity and/or their representative, information from or copies of medical records pertaining to me, providing such company or entity is directly concerned in the payment or authorization of cost of my medical treatment.

2. **Medicare/Medicaid Claims**: Client's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized Medicare benefit be made either to me or on my behalf for any services furnished by Serenity Now including physician services. I authorize any holder of medical and/or other information about me to release to Center for Medicare and Medicaid Services and its agent any information needed to determine these benefits or benefits for related services.

3. **Assignment of Insurance Benefits**: I agree that any benefits of any type arising out of any policy of insurance for me, or any other party liable to me, are hereby assigned to Serenity Now or treating health care provider that renders services for which an assignment if applicable. I understand that I am financially responsible to Serenity Now or treating health care provider for charges not covered by this authorization.

4. **Financial Agreement**: The undersigned agrees, whether he/she signs as agent or as a client that in consideration of the services to be rendered to the client he/she hereby individually obligates himself/herself to pay the account of Serenity Now and treating health care provider in accordance with the regular rates and terms of said providers. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the rate of eight percent (8%).

5. **Co-pays and Co-insurance:** The undersigned understands that all copays are due at the time of service. If the client has co-insurance, where the client is responsible for a percentage of the allowable charges, the undersigned agrees to make a payment at the time of service based on the estimated co-insurance for which the client will be responsible. If this estimate results in overpayment, the account balance will be credited for future visits. A refund will be applied upon request.

6. **HIPAA Notice of Privacy Practice**: The undersigned hereby acknowledges being advised of the HIPAA Notice of Privacy Practice of Serenity Now and has been offered a written copy of that document. If the undersigned does not accept a copy of the same at this point in time, he/she understands that he/she is bound by the terms of said Notice of Privacy Practice of Serenity Now and may request a copy at any time.

7. **Teaching facility**: The undersigned hereby acknowledges that Serenity Now is a teaching facility and therefore often has student interns involved in the treatment team process. This may include having interns observe and/or participate in therapy sessions and medication management visits. All student interns are held to the same standards as any other Serenity Now staff member and sign confidentiality agreements in compliance with all HIPPA regulations.

8. **Legal and Forensic Services**: The undersigned acknowledges that fees will be charged and payment in full expected prior to the appearance of any providers subpoena to appear in court. Charges will be per hour for each hour provider is expected to commit to the proceedings, including travel to and from the location where the legal proceedings occur and the Serenity Now office.
9. **Appointments and Treatment Plans**: The undersigned understands that it is necessary for a treatment plan to be followed and a lack of compliance with the treatment plan or failure to attend, or, in the alternative to cancel more than 24 hours in advance 3 appointments within a 6-month period may result in termination of services. I further understand that I will be charged a fee of $50.00 for any missed appointments that are not cancelled more than 24 hours in advance. This charge will have to be paid in full prior to any future appointments being scheduled.
   As part of the treatment plan to be followed, drug screens may be required. If any drug screen is ordered, it shall take place within forty-eight (48) hours of the request, excluding Saturdays, Sundays and legal holidays.
   Serenity Now will notify the undersigned in the event there is termination of services and will provide names of other local providers.
9. **Current Information**: The undersigned agrees to provide current address and telephone number(s) and in the event these change, it shall be the responsibility of the undersigned to present that information to Serenity Now.

10. **Permission to Call**: That the undersigned further agrees that Serenity Now shall have the authority to contact me at the telephone number(s) and email addresses provided to remind me of appointments.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, RECEIVING A COPY OR OFFERED A COPY THEREOF, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Client Signature:_____
(if client is a minor or under guardianship, the person who is taking the responsibility must sign below)
Responsible party:_____
Relationship:_____
Date:_____

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I understand the policies listed below and agree to them as a condition of receiving treatment at Serenity Now Psychiatric & Counseling Services:

- Failure to attend a scheduled appointment, or failure to cancel a scheduled appointment more than 24 hours in advance, may result in a **$50 fee**.
- This fee **must** be paid prior to the next scheduled appointment.
- **Three** no-shows or late cancellations within a 6 month period, may result in termination of services.
- In addition, more than **6** cancellations, reschedules, no-shows, and/or late cancellations within a 1 year time period, may result in termination of services.
- A late cancellation or now show with your therapist may also result in the cancellation of all future scheduled appointments at Serenity Now until you are seen by your therapist again.

- As a courtesy, Serenity Now will send out reminders **2 days** before the scheduled appointment. These reminders are only a courtesy to our clients. If you do not receive a reminder, you are still responsible for attending your appointment or rescheduling no later than 24 hours before your appointment to avoid the no show or late cancelation fee.

- If you no show or late cancel an appointment, Serenity Now holds the right to **not** refill your prescription medication until your next appointment with your medication provider.

_____ _____

Client Signature Date

Note: If client is a minor or under guardianship, parent/guardian must sign

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Client Rights and Responsibilities

As a client of Serenity Now Psychiatric and Counseling Services, you have certain rights while receiving services. It is important that you are knowledgeable and understanding of the services you will receive. This consent acknowledges your voluntary participation and your understanding of these client rights. As treatment begins, you will be asked to participate in the development of your treatment goals.

Client Rights

- To receive quality treatment from trained clinical professionals and to be treated with respect.
- To be free from abuse, neglect, financial or other exploitation, retaliation, or humiliation.
- To be provided with information about treatment options and their effectiveness.
- To be given information about consent, refusal or expression of choice regarding services, release of information, service providers, and involvement in research projects if applicable.
- To receive services without regard to your race, color, spiritual belief, gender, sexual orientation, age, disability, language, social and economic standing, or national origin, familial status, or status as a veteran
- To refuse treatment at any point in time.
- To be provided with information concerning side effects of medication that may be prescribed.
- To look at your medical record, upon approval of your treatment team, and a written request for copies.
- To your constitutional, statutory, and civil rights, except as denied or limited by a legal proceeding.
- To be involved in your treatment plan.
- To be treated in a setting that is most beneficial for your treatment.
- To tell staff or others if you have a complaint about a staff member or services without having to worry about the complaint affecting your treatment.
- To privacy during your appointment.
- To have information about you and the services you receive kept confidential, unless you give us permission, or the law states we must share information with others.
- To have your records protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and your records cannot be disclosed without your written consent unless otherwise provided for in state or federal regulations.
- To obtain the names, qualifications, and titles of the professionals providing your care.
- To be referred to legal entities and private practitioners of your choice at your own expense if requested.
- To be provided with information and/or referred to self-help and advocacy services.
- To be assured of adherence to research guidelines and ethics, if applicable.
- To be assured that alleged infringement of rights will be investigated and resolved in a timely manner.

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Client Responsibilities

• To respectfully treat staff the same way you want them to treat you. • To come to your scheduled appointments on time, or call 24 hours before your appointment to cancel and reschedule. • To inform the staff of all information that will assist them in helping you.	• To follow your treatment plan and take your medications if they apply to your treatment plan. • If you attend group counseling or education sessions, keep any information others in the group share with you confidential. • To pay your share of the costs of your treatment and have your insurance billed.

Client Complaint Process

If you ever have a concern about your treatment, it is important that the concern be addressed as soon as possible. The following process will assure that your concerns are heard:

• Discuss the concern with your therapist and try to work it out with that person. • If you are still unsatisfied, contact the Office Manager.	• The Office Manager will hear your concerns and work to find a solution within 7 business days. • If you believe your concern has still not been addressed, a member of the Serenity Now leadership team will become involved and will help to reach a satisfactory resolution.

I acknowledge that I have received and reviewed these Client Rights and Responsibilities.

_____ _____

Client Signature **Date**

Note: If client is a minor or under guardianship, parent/guardian must sign

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Consent for Release of Prescription History

I authorize Serenity Now to access my prescription history from unaffiliated medical providers, insurance companies, pharmacy benefit managers and the SureScripts database, to help keep my medical record as complete as possible. I understand that my prescription history from other sources may be viewable by the providers and staff within Serenity Now, and may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Printed Patient Name Date

_____

Signature

Note: If client is a minor or under guardianship, parent/guardian must sign

My preferred pharmacy is _____

Location:_____

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Telehealth/Virtual Treatment Consent Form

This form serves as a consent for all telehealth/tele behavioral health/virtual appointment services (referred to on this form as "telehealth services") provided by Serenity Now Psychiatric and Counseling Services.
Telehealth is the use of the internet to provide remote care for clients/patients. Specifically, your healthcare provider will communicate with you remotely via the internet using Doxy.me, a web-based, HIPAA compliant, audio-video software. Doxy.me only hosts the software and does not provide medical advice or information.
At Serenity Now, such care may come from our doctor/psychiatrist, nurse practitioner, or master's level clinicians. These telehealth services may be used for diagnosis, continuity of care, treatment, testing, or medical consultations deemed necessary by you and/or your provider.
You are not required to sign this form if you do not wish to be seen via telehealth/virtually.

I understand that:
Parent/Guardian (if client is a minor or under guardianship) or Patient must initial each line.

____ telehealth services can only be provided to clients/patients, including myself, who are **in the state of Indiana** at the time of service, and failure to comply and verify my location during the visit may result in termination of the visit

____ details of my medical history and personal health information may be discussed with me during my treatment over telehealth, including sensitive medical information such as substance use or addiction, sexually transmitted diseases, or HIV/AIDS

___ information exchanged during my telehealth visit will be maintained by the healthcare provider and facility involved in my care

___ all confidentiality protections granted to me by various state and federal laws also apply to my care during a virtual appointment

___ there may be security and privacy risks associated with internet-based communications

___ the healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me

___ there are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider

___ either my healthcare provider or I can terminate the telehealth appointment if either of us feels that remote communication is not adequate for diagnostic decision-making or for providing the care I desire

___ I may opt out of the telehealth visit at any time and this will not change my ability to receive future care at this office

___ I will be informed of any other person(s) who may be present during the appointment in addition to my healthcare provider and have the right to have them leave the viewing and listening area

___ it is my responsibility to maintain my privacy. Therefore, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the telehealth appointment

___ I have the right to omit or withhold specific details of my medical history/physical examination that are personally sensitive

___ telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage

___ my healthcare provider may advise me to seek immediate treatment or determine there is an emergency and, as such, local authorities may be given my personal details to assist me

___ the communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my healthcare provider

___ electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

Therefore, by consenting to the use of telehealth services:

1. I desire to engage in remote audio-visual communication with my healthcare provider.
2. I understand the risks and benefits of using internet-based communications and that no results can be guaranteed.
3. I acknowledge that if the healthcare provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
4. I understand that I may be responsible for co-payments, deductibles, or other charges from my healthcare provider, and additional charges may occur for services related to this appointment, and that co-payments are due at the time of service.
5. I understand that some parts of my care involving physical tests or in-office treatment may be required and conducted by individuals at my location, or at a testing facility, at the direction of my healthcare provider.
6. I have the ability to ask direct questions to my healthcare provider about this appointment, including details about my healthcare provider's privacy policy. If my questions are not answered to my satisfaction, I have the right to terminate the appointment.
7. I am at least 18 years of age.

Patient Signature _____ Date _____

Note: If client is a minor or under guardianship, parent/guardian must sign

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Consent for Use of AI/Virtual Scribe During Appointments

At Serenity Now Psychiatric and Counseling Services, we aim to provide the best possible care for our clientele. In an effort to do this, we are now using HIPAA compliant AI platforms/tools, which are artificial intelligence tools that help summarize what is said in appointments. This technology allows the provider to focus more on you, the client, in your sessions, and not be distracted by as much typing and other documentation. However, your provider is still responsible for reviewing the content for accuracy and completeness.

How is a Virtual Scribe utilized?

We only use HIPAA-compliant AI tools that listen to the conversation during an appointment, transcribe, and create a written summary based on that conversation. The summary is then reviewed for accuracy, edited, and signed by the provider. These virtual scribes work in the background, and do not interact with the provider or client directly. Outside of the completion of this consent form, the use of the tool should not interrupt or interfere with your sessions should you consent to its use.

Data Privacy and Confidentiality

Virtual scribes and AI tools ensure the security of the transcribed conversation by adhering to HIPAA-compliant data storage and processing protocols. Furthermore, the recording of the conversation is temporarily and securely stored until the session summary is complete, and is then automatically deleted. For most virtual scribes, the standard deletion time for session summaries is 30 days; if needed, the provider can manually delete the information sooner. For others, the information is securely stored until the provider deletes the information, and/or a deletion schedule can be automated. On some of these tools, the data is stored under a pseudonym so that personal data is not directly identifiable.

Consent

Client participation is completely voluntary. Please let your provider know if you have any additional questions. If the client or parent/guardian wishes to revoke consent for using these tools in the future, please let your provider know. Choosing not to use these tools will not negatively impact a client's care.

☐ I agree to the use of HIPAA-compliant virtual scribes/AI tools during my/my child/dependent's appointments at Serenity Now Psychiatric and Counseling Services

Signature: _____

Name (Printed): _____

Client's Name (if different from above): _____

Relationship to Client: _____

Date:_____

Rev 04.2025

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Information Release Form (HIPAA Release Form)

Only for patients 18 yrs and older

Patient Name: _____ Date of Birth: _____/_____/_____

I give authorization for Serenity Now to release the specified protected health information to the following individual(s):

Note: boxes must be marked next to individuals listed regarding information to be disclosed

- Spouse_____ Date of Birth_____/_____/_____
  Phone: _____
  ☐ Appointment Information/Prescription Pick-Up ☐ Lab and Test Results
  ☐ Diagnosis and Treatment Information ☐ All Protected Health Information

- Child_____ Date of Birth____/_____/_____
  Phone: _____
  ☐ Appointment Information/Prescription Pick-Up ☐ Lab and Test Results
  ☐ Diagnosis and Treatment Information ☐ All Protected Health Information

- Other_____ Date of Birth_____/_____/_____
  Phone: _____
  ☐ Appointment Information/Prescription Pick-Up ☐ Lab and Test Results
  ☐ Diagnosis and Treatment Information ☐ All Protected Health Information

_____ _____

Printed Patient Name Date

_____

Signature

Note: If client is a minor or under guardianship, parent/guardian must sign

Notice to Recipient of Client Records/Information:
Information pursuant to this authorization has been disclosed to you from records which may be protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. The receiving organization/party is advised and should understand that some or all of the information provided pursuant to this release may not be re-released without the further consent of the client/patient except as allowed by statute, rule or regulation. The receiving organization/party will be solely responsible for any unauthorized disclosure or use. This authorization to disclose was developed to comply with the provisions regarding disclosures of medical and mental health records, alcohol and drug abuse records and other information under: Serenity Now Policies: 42 CFR Part 2; Indiana statutes, regulations, and case law; and HIPPA.

Revised 07/23. 06/24.

Serenity Now Psychiatric & Counseling Services
(A Division of Hoosier Uplands Economic Development Corporation)
2125 16th St. Bedford IN. 47421
(812) 275-4053

MINOR CHILD CUSTODY AND RELEASE

Information Release Form

Patient Name: _____ Date of Birth: _____/_____/_____
Biological Parents/Legal Guardians:_____
_____

I give authorization for Serenity Now to release the specified protected health information to the following individual(s):

Note: boxes must be marked next to individuals listed regarding information to be disclosed

- Step-parent_____ Date of Birth_____/_____/_____
  Phone: _____
  - ☐ Appointment Information/Prescription Pick-Up ☐ Lab and Test Results
  - ☐ Diagnosis and Treatment Information ☐ All Protected Health Information
  - ☐ Make any decisions related to my child's treatment in my stead

- Step-parent_____ Date of Birth____/_____/_____
  Phone: _____
  - ☐ Appointment Information/Prescription Pick-Up ☐ Lab and Test Results
  - ☐ Diagnosis and Treatment Information ☐ All Protected Health Information
  - ☐ Make any decisions related to my child's treatment in my stead

- Other_____ Date of Birth_____/_____/_____
  Phone: _____
  - ☐ Appointment Information/Prescription Pick-Up ☐ Lab and Test Results
  - ☐ Diagnosis and Treatment Information ☐ All Protected Health Information
  - ☐ Make any decisions related to my child's treatment in my stead

_____ _____
Printed Patient Name Date

_____
Parent/Guardian Signature

Notice to Recipient of Client Records/Information:
Information pursuant to this authorization has been disclosed to you from records which may be protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. The receiving organization/party is advised and should understand that some or all of the information provided pursuant to this release may not be re-released without the further consent of the client/patient except as allowed by statute, rule or regulation. The receiving organization/party will be solely responsible for any unauthorized disclosure or use. This authorization to disclose was developed to comply with the provisions regarding disclosures of medical and mental health records, alcohol and drug abuse records and other information under: Serenity Now Policies: 42 CFR Part 2; Indiana statutes, regulations, and case law; and HIPPA.

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Controlled substance medications (i.e. Benzodiazepines, stimulants) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. In the event that I am prescribed a controlled substance medication, I agree to the following:

Parent/guardian (if client is a minor or under guardianship) or Patient Must Initial Each Line

_____1. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if I increase the use of my medication without prior approval from the office, I understand that this medication may not be replaced regardless of the circumstances.

_____2. I understand that many of these medications are intended for short term use as needed.

_____3. I agree to sign a release of information for my insurance provider, primary care physician and other pertinent prescribers. I also understand that this includes information regarding treatment and any relevant diagnosis.

_____4. I agree to report **all** medications being prescribed to me by other providers. I understand that failure to do so could result in discontinuation of controlled substance medication prescribing by Serenity Now and potential discharge from services.

_____5. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining pills.

_____6. I understand that I am solely responsible for attending scheduled appointments. I also understand that failure to do so may result in delays in obtaining a prescription refill, or may result in refills being withheld.

_____7. If I require a refill prior to a previously scheduled appointment, I understand that I must contact the office **5 full business days** prior to the end of my prescription to minimize risk of delays in processing the prescription. Failure to do so may result in processing delays to obtain refills of the prescription.

_____ 8. I understand and agree to comply with random urine or oral drug testing and pill counts, thereby, documenting the proper use of any medications, as ordered by my prescribing medical provider.

_____ 9. I understand that I must come in for random drug screens or pill counts within 48 hours of being notified.

_____10. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, overdosing on the medication or in combination with the use of non-prescription illicit (illegal) drugs, I may also be reported to my primary care physician and other pertinent prescribers.

_____11. I understand that the long-term advantages and disadvantages of chronic benzodiazepine and stimulant use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances.

_____12. I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____ 13. I understand that the use of alcohol while prescribed a benzodiazepine is considered non-compliance with medication directions and can lead to discontinuation of benzodiazepine prescriptions and potentially dismissal from this facility.

_____ 14. I understand that the use of marijuana and hemp products, including CBD and Delta-8 variants, is completely disallowed while prescribed a controlled substance, such as benzodiazepines, regardless of whether or not I was in a locale where marijuana or hemp products are legal substances. Any violation of this can lead to the discontinuation of prescriptions for controlled substances. Failure to comply can lead to dismissal from this facility.

_____15. I understand that some individuals may develop a physical dependence and/or addiction to these medications. This may occur if I am on the medication for several weeks. Stopping these medications too quickly can result in adverse reactions that could be potentially life threatening. Therefore, I agree to seek medical supervision before stopping any prescribed medications.

_____16. All controlled substances will be written for only one month at a time. While on a controlled substance I will be seen in the office every 1-3 months.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice evidence-based medicine in the safest and most efficacious manner possible while complying with all local, state, and federal regulations.

Patient Signature _____ Date _____

Note: If client is a minor or under guardianship, parent/guardian must sign