Serenity Health & Wellness

Registration Form

Today's Date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First:	M.I	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ In a relationship

Is this your legal name? ☐ Yes ☐ No	If no, what is your legal name?	Email Address:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Mailing Address: (City) (State) (ZIP Code)

Social Security #: - -	Home phone #: ( ) -	Cell phone #: ( ) -
Occupation:	Employer Name:	Work Phone #:

Is this a work related Injury? ☐ YES ☐ NO

If yes, Please provide name, contact number and claim number for injury:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card/s to the front office staff)

Person responsible for today's visit:	Phone #:	Relationship to patient:	Home phone # of responsible:

Primary Insurance:	Subscribers name:	DOB of subscriber:	ID/Policy #:	Group #:

Patient's relationship to subscriber: ☐ Parent/Guardian ☐ Spouse ☐ Other _____

Secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy/ID #.:

Patient's relationship to subscriber:

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Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Serenity Health & Wellness. I understand that I am financially responsible for any remaining balance that my insurance does not pay. I also authorize Serenity Health & Wellness as well as Rainbird Billing to release any information required to process my claims.

Patient/Guardian signature

Today's Date

Serenity
Health & Wellness

RECEIPT OF NOTICE OF PRIVACY PRACTICES/CONSENT FOR SERVICES

I have reviewed/received a copy of Serenity Health & Wellness's 'Notice of Privacy Practices'. (reviewed does not indicate I have read, understand or agree with the notice).

I consent (agree) to receive medical services: I, the undersigned hereby agree and consent to the plan of care proposed to me by the service practitioner to whom I have seen. I will ask for any information that I may have about my services and will make my wishes known to the practitioner and/or staff.

I hereby give my consent for Serenity Health & Wellness to use and disclose protected health information (P.H.I) about me to carry out treatment, payment and other healthcare related operations.

(The 'Notice of Privacy Practices' provided by Serenity Health & Wellness describes such uses and disclosures.)

I have the right to review the 'Notice of Privacy Practices' prior to signing this consent. Serenity Health & Wellness reserves the right to revise Its 'Notice of Privacy Practices' at any time.

I have the right to request that Serenity Health & Wellness restrict how it uses or discloses my P.H.I to carry out treatment, payment and other healthcare related operations. The practice is not required to agree upon my requested restriction, but if it does, it is bound by this agreement.

_____ _____ _____

Print Name Signature of patient/guardian Date

FINANCIAL AGREEMENT/MISSED APPOINTMENTS

(Initial each section)

_____ I agree to contact the clinic if I cannot make a scheduled appointment at least 24 hours in advance whenever possible. I understand that failure to do so in a timely manner may result in a **"No Show" fee of $25.00 per missed visit.**

_____ I understand that if I miss more than two (2) scheduled visits per calendar year, it may result in the termination of my patient/provider relationship with Serenity Health & Wellness.

_____ I understand that I am financially responsible for the remaining balance of my account after insurance has been billed.

_____ _____ _____

Printed Name Patient/Guardian Signature Date