NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of Serendipity Wellness Center's Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the Privacy Officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

OFFICE PROCEDURES

I hereby give consent to Serendipity Wellness Center to provide treatment and services the assigned provider may deem necessary. I understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefits to be paid directly to Serendipity Wellness Center for professional fees. I understand that I am responsible for charges not covered by my insurance policy. I understand that any amounts which are 90 days past due could be eligible for potential collections and turned over to a Collection Agency, unless prior arrangements have been made with the Business Administrator. I understand that I am responsible for a fee of $25.00 for any returned check. I understand that I may need to assist in obtaining my medical records and may be charged if Serendipity Wellness Center is billed a fee for medical records.

RELEASE OF CONFIDENTIAL INFORMATION & AUTHORIZATION

I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original will be placed in my patient file to be kept in medical records. I hereby consent and grant permission for Practitioners employed by Serendipity Wellness Center to discuss my medical treatment with my referring physician, primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment. I hereby authorize any practitioner examining and/or treating me, to release to any third party (such as an insurance company) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms. I hereby consent and authorize Serendipity Wellness Center to file medical claims for treatment, electronically or manually to my insurance carrier(s) for services rendered to me.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to provider Serendipity Wellness Center for services rendered for any services and treatment. Any services for which assignment is accepted but are not covered under my insurance policy are acknowledged as being my full and complete financial responsibility.

I have read, understand and agree to all the above.

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date signed