7959 Fredericksburg Rd. Ste. 135 San Antonio TX. 78229 / 8305 Shoal Creek Blvd. Austin TX. 78757

Serenity Medical Centers

# PATIENT DEMOGRAPHIC SHEET

First Name: _____ Last Name:_____ DOB: _____

Home Address: _____

City/ State/ TX.: _____ Phone: _____

Social Security: _____ Marital Status: _____ Primary Language: _____

Email: _____ Best Contact Method: _____

Emergency Contact Name: _____Phone: _____

Relationship: _____

# MAJOR MEDICAL INSURANCE INFO

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Relationship to subscriber: _____

Policy# _____ Group#_____

Claims Address_____
_____Claims Phone# _____

## WORKER'S COMP

FWC Claim # _____ Date of Injury: _____

Injured Body Part (s) _____

Date CA-1/ CA-2 Completed: _____ Initial Narrative Completed? YES NO

SWC Claim#: _____ Body Part(s): _____

Insurance Company Name: _____

Insurance Company Address: _____

Pharmacy Name: Address:

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## CONSENT FOR TREATMENT & CARE

I hereby request and consent to the performance of treatment and/or procedures by physician, or chiropractic adjustments and other chiropractic procedures, including various modes of rehabilitation services, physical therapy, and diagnostics on me (or patient named below for whom I am legally responsible for) by the physician or Doctor of Chiropractic and/or other license doctors who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor, including those working at the clinic or office listed below or any other office or clinic.

Initials: _____

Serenity Medical Centers utilizes Physician Assistants to assist in the delivery of medical care. **Physician Assistants are under the supervision of a physician.** You will always see the physician at your initial visit to diagnose you and create your treatment plan. Thereafter, you may be seen by a Physician Assistant who can treat and monitor common acute and chronic diseases with physician supervision. I hereby consent to the services of a PA for my health care needs. I understand that at any time I can refuse to see a PA and request to see the physician.

Initials: _____

I have had the opportunity to discuss with the doctor and/or other office or clinic personnel the nature and purpose of treatment and procedures.

I understand and am informed that in the practice of medicine there are some risks to treatment. In the practice of chiropractic, these are included but not limited to, fractures, disc injuries, strokes, dislocations or sprains. I do not expect physician to be able to anticipate or explain all risks and complications. I wish to rely on the doctors to exercise judgement during the course of treatment which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read and/or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent, and by signing below, I agree to the recommended treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ PRINTED NAME OF PATIENT

_____ PRINTED NAME OF GUARDIAN/PARENT

_____ SIGNATURE OF PATIENT

_____ SIGNATURE OF GUARDIAN/PARENT

_____ DATE

_____ DATE

# ASSIGNMENT OF BENEFIT AGREEMENT

I _____, in addition to continuing personal responsibility, in consideration of treatment rendered by **Sholar-SERENITY MEDICAL CENTERS**, including all providers, all services at 7959 Fredericksburg Rd. Ste. 135 San Antonio Texas 78229 and/or 8305 Shoal Creek Blvd. Austin Texas 78757, or any other **SHOLAR-SERENITY MEDICAL CENTERS** location, agree to the following:

1. **RELEASE OF INFORMATION**: The above referenced physician shall have the authority to release any information concerning the patient's condition and treatment to any insurance company, attorney, or insurance adjuster, for the purposes of processing any relevant claim for benefits and payment of services rendered to the patient. Information may ONLY be released upon proper written request to do so by said insurance company, attorney or insurance adjuster, any other release of information regarding the patient shall be accomplished by execution of a separate "Release of Information" agreement.

2. **IRREVOCABLE ASSIGNMENT OF RIGHTS**: Said physician is hereby assigned the exclusive irrevocable right to any cause of action that exists in the patient's favor against any insurance company for benefits owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in his/her name for payment , and prosecute and receive penalties, interest, court cost, or other legally compensable amounts by an insurance company in accordance with Article 3.62 of the Texas Insurance Code or other applicable insurance or state statute. The patient and/or responsible party further assists in the prosecution of such claims for benefits upon request.

3. **AUTHORIZATIONS & DIRECTIVES**: The patient and/or responsible party hereby authorizes and directs any and all insurance companies, known or unknown, providing benefits of any kind to such patient DIRECTLY to the above referenced physician, such sums as may be due and owing him for the services rendered to the patient with in 60 days following the insurance company's receipts of such bills for services, along with a copy of the Agreement, to the extent such bills are payable under the terms of the relevant policy. This demand specifically conforms to Article 3.62-1 of the Texas Insurance Code, providing for attorney fees, 12% penalty, court costs and interest from judgement upon violation. Any and all insurance companies, weather known or unknown at the time of execution of this Agreement shall be authorized to withhold any such sums from any settlement, judgement, or verdict paid over the insurance company or policy holder as may be necessary to adequately protect the physician here-under, hereby granting a lien in favor of the physician against any and all proceeds from settlement, judgement, or verdict. In the event any or all insurance companied, weather known or unknown, fail or refuse to make such a payment to the physician as herein above directed, said physician is hereby assigned and transferred any and all cause of action that may exist in the patient's favor, authorizing him to prosecute such action, either in the patient's name or as otherwise legally required, to further grant authorization to compromise, settle or otherwise resolve said claims in his sole discretion . It is

acknowledged that whatever sums left outstanding from payment of insurance is the personal obligation of the patient and/or responsible party, as is the power to collect the sums due from the relevant insurance company(s). Further, the patient and/or responsible party agrees that, if there is a unpaid balance owed to the physician, and insurance benefits are received directly by the patient and/or responsible party, he/she will immediately pay the amount owed in full. Upon failure to pay insurance benefits to the physicians, the patient agrees to pay attorney fees and court costs incurred if legal action is required against the patient by the physician.

4. **STATUTE OF LIMITATIONS**: The patient hereby waives the right to claim statute of limitations regarding claims for services rendered or to be rendered by physician named above, in addition to a reasonable cost of collection, including attorney fees and court cost, if incurred, until four (4) years after all causes of action for recovery under the applicable policies have been resolved by final judgment, settlement or dismissal.

5. **LIMITED POWER OF ATTORNEY FOR INSURANCE BENEFITS**: The patient and/or responsible party hereby grants to the above referenced physician power to endorse the name of the patient upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing an amount in the excess of the charges for treatment and health care rendered by said physician. The patient agrees that any insurance payment representing an amount in excess of the charges for treatments rendered will be credited to the patient's account or forwarded to the Patient's address upon request in writing to the physician named above.

Patient Signature: _____ Date: _____

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**HIPPA DISCLOSURE LETTER**

Dear Patient

We consider the privacy of your health information to be one of the most important elements in our relationship with you. Our responsibility to maintain the confidentiality of your health information is one that we take very seriously. We have taken the following steps to protect your privacy:

- We train our staff members on their responsibility to maintain the confidentiality of your health information and hold them accountable for their actions.
- We do not sell your information to any organization.

Federal Legislation concerning patient privacy requires health care providers, health insurance companies, and other health related organizations to bolster their privacy practices as of April 14, 2003.

Attached with this letter are Acknowledgement Form and Notice of Privacy Practices for Protected Health Information (PHI). We are pleased to provide this information to our patients and to comply with the privacy regulations of the Federal Health Insurance Portability and Accountability Act. (HIPAA). To help us comply with this law, we ask that you do the following:

1. Complete the HIPPA Acknowledgement form.
2. Read the Notice of Privacy Practices for Protected Health Information

I hereby acknowledge that I have received a copy of SERENITY MEDICAL CENTERS Notice of Privacy Practices for PHI. I further acknowledge that a copy of the current notice will be available upon request and that I will be offered a copy of any amended Notice of Privacy Practices for PHI.

_____ _____

Printed name of patient or responsible party Date

_____

Patient Signature

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# Missed Appointment Policy

Our clinic encourages all of our patients to attend regularly scheduled appointments for their therapeutic benefit and for the efficient operation of our clinic. In the event that a patient must miss a scheduled appointment, Serenity Medical Centers requires the patient to ***inform their provider of the cancellation at least twenty-four (24) hours prior to the beginning of the scheduled appointment***.

Patients can either leave a message on the individual clinic phone (Austin: 512-646-2743, San Antonio: 210-892-3811 or Maria Cash 512-952-0349) or send email to maria.c@medcenters.org to cancel an appointment.

Patients who miss any scheduled appointment without providing the required notice of at least 24 hours will be charged a ***missed appointment fee*** of twenty-five dollars ($25) for the missed session and for each subsequent missed appointment.

Serenity Medical Centers, at its discretion, may waive a missed appointment fee in the event a cancellation is deemed to be due to an emergency.

Serenity Medical Centers, at its discretion, may discontinue providing treatment to patients who miss their scheduled appointments without providing the required 24-hour notice. These patients will be referred to another provider in the community.

My signature below constitutes my acknowledgement that I have read and hereby agree to comply with the above policy.

_____ _____

Patient Signature Date

_____ _____

Witness Date

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# PHOTO CONSENT FORM

I, _____grant permission to **SERENITY MEDICAL CENTERS** for the use of the photograph(s) or electronic media images as identified below in any presentation of any presentation of any and all kind.

I understand that I may revoke this authorization at any time by notifying **SERENITY MEDICAL CENTERS** in writing. The revocation will not affect any action taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

Name: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

**ORIGINAL PHOTO WILL BE KEPT SECURE IN PATIENT'S CHARTS AND / OR IN A PASSWORD – PROTECTED DIGITAL FILE.**