VIRTUE MEDICINE P.C.

Clinics for Mind-Body Health

Studio for Ethics & Contemplative Arts

New Patient Agreement

(Please initial each information block)

Privacy and Confidentiality:

___I have had an opportunity to review the privacy and confidentiality policies used by practitioners at Virtue Medicine P.C., available at both the office site and at the business website.

___I understand that my medical information will be held in strictest confidence and will not be released without my oral or written permission with the following exceptions: 1) a life-threatening medical emergency or public safety risk, and then only to persons to help reduce or prevent the threat, or 2) when required to do so by law or by legal proceedings. If health information is released under these exceptions, I will be notified by the practice as soon as possible.

___Although the medical records are the physical property of Virtue Medicine P.C., the information belongs to me. If I would like a copy of the records for my own use or to provide to another health care provider, the office will happily provide the copy at a small charge to me. If I believe that information in the record is incorrect or that something important is missing, I have the right to request an amendment of the record in writing.

Therapeutic Relationship:

___At the Virtue Medicine P.C. Clinics, I have the right to:

- Receive respectful and competent treatment within the provider's scope of practice.
- A safe treatment setting, free from sexual, physical, and emotional abuse.
- Report any immoral and illegal behavior by the provider.
- Request and receive information concerning my provider's qualifications, including licensing, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Request and receive written information concerning fees, methods of payment, insurance participation, course of treatment the provider believes will be needed, substitute health care providers (in cases of vacation and emergencies), and cancellation policies.

___I agree that medical care with my provider is voluntary and can be discontinued at any time. My provider also has the right to discontinue services immediately if she judges that a therapeutic relationship cannot be maintained or if the clinical and reception spaces are being disrupted by my conduct. Notice of discontinued treatment will be provided in writing.

___I understand that if there have been more than 24 months since my last medical appointment in the practice, requests for follow-up will be scheduled as a new patient evaluation appointment to allow sufficient time to update medical information.

___Psychiatric and psychological care are professional services, and the therapeutic relationship with my provider at Virtue Medicine is different from other kinds of relationships. I understand that this limits other kinds of relationships my provider may have with me or with my family now or in the future, in accordance with professional standards, including close friendships and direct business arrangements such as employment.

Appointments and Cancellations:

___*Appointments are a valuable resource*. Cancellation must occur through *phone notification* to Virtue Medicine P.C. Reception (319-338-5190) at least 24 hours in advance; Monday appointments must be cancelled by 5 p.m. (Central) of the preceding Friday. If I miss an appointment without the 24 hour cancellation, I understand that I will be billed for the full amount of the scheduled visit by mail or at the next office visit and that this charge is not reimbursable by a third party payer.

Payment:

___I understand that this office is a fee-for-service practice and payments for service are due in full at the time of the appointment. If phone/email consultations or paperwork are requested other than during scheduled appointments, time spent in service will be billed to me by mail or at a subsequent office visit in accordance with the fee schedule.

Telephone/Email Contacts and Emergencies:

___I understand that my private email is not a secure form of communication and that email is not necessary to my care plan at Virtue Medicine P.C. If I initiate an email to my provider, I understand that I am authorizing my provider to use this mode of communication for providing medical information and accept the liabilities entailed with this form of communication. If I do not wish to accept the liabilities of email, I will not use that mode of communication with my provider.

___I understand that if I leave a message by phone/email for my provider, I may expect a return message within 48 hours of her clinic hours, which are posted. If my provider is on leave, directions on coordinating needs through the provider office staff will be provided. Messages left for Virtue Medicine Reception will be returned within one business day, Monday through Friday.

___I understand that my provider runs a small consulting practice without full after-hour service options. 24-hour access to Virtue Medicine P.C. providers is not available. I understand that I am responsible for having a primary care physician who is aware of my psychiatric/psychological care and medications and can be contacted with medical emergencies. I understand that *urgent assistance for safety issues can be found at:* **911 or local emergency room***, the Johnson County Crisis Line at* **319-351-0140** *or online at http://jccrisiscenter.org/.*

___I agree that in an emergency, I will call 911 or seek attention at my nearest emergency room.

My signature below demonstrates that I have read, understand and agree to abide by the terms of this agreement for the duration of my care with my provider at Virtue Medicine P.C.

_____ _____

Patient Signature Date