VIRTUE MEDICINE P.C.

Clinics for Mind-Body Health

Studio for Ethics & Contemplative Arts

Patient Agreement for: _____

Privacy and Confidentiality:

☐ I have had an opportunity to review the health care privacy and confidentiality policies, available at both the office site and at the business website, which are used by the doctors at Virtue Medicine, P.C.

☐ 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 doctor's practice as soon as possible.

☐ Although the medical records are the physical property of the doctor, the information content belongs to the patient. 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, with a small handling fee. 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 by providing a specific written request to the doctor.

Therapeutic Relationship:

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

- Receive respectful and competent treatment within the doctor's scope of practice.
- A safe treatment setting, free from sexual, physical, and emotional abuse.
- Report any immoral and illegal behavior by the doctor.
- Request and receive information concerning my doctor'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 health care with my doctor is voluntary and can be discontinued at any time. My doctor 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 12-24 months since my last medical appointment in the doctor's clinic, requests for follow-up will be scheduled as a new patient evaluation appointment, at the discretion of the doctor, to allow sufficient time to update medical information.

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 the doctor's clinic 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 doctor or to Virtue Medicine Reception, I understand that I am authorizing the use of 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.

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

☐ I understand that Virtue Medicine P.C. have consulting medical practices, not primary care practices, and there are no after-hour service options or 24-hour access.

☐ I understand that I am responsible for having a primary care physician who is aware of my health care and medications and can be contacted with medical emergencies. I understand that any *urgent or emergent assistance for health issues can be found at:* **911 or the local emergency room**. *Additional resources for mental health safety can be found at 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 doctor at Virtue Medicine P.C.

_____ _____

Patient Signature Date

_____

Please Print Name