Renee Gullickson, DNP, ARNP, FNP-BC, PMHNP-BC
Wellness Provider

New Patient Agreement

(Please initial each information block)

Privacy and confidentiality:

____I have had an opportunity to review the HIPPA policies as are posted and implemented in this office.

____I understand that my medical information will be held in strictest confidence and will not be released without my 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 threat, 2) when required to do so by law or by legal proceedings. If protected 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 Renee Gullickson, DNP, ARNP, 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.

Provider-Patient Relationship:

____At Eastwind Healing Center and with Dr. Gullickson, I have the right to:

- Receive respectful and competent treatment.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a provider or therapist.
- Ask for and get information about my provider's qualifications, including licensing, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information about fees, method of payment, insurance coverage, 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 Dr. Gullickson is voluntary and can be discontinued at any time. Dr. Gullickson 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 evaluation in the practice, requests for follow-up will be scheduled as a 60-minute patient intake/evaluation appointment to allow sufficient time to update medical information.

____Medical care is a professional service, and the therapeutic provider-patient relation is different from other kinds of relationships. I understand that because Dr. Gullickson is my provider, this limits other kinds of relationships she may have with me or with my family now or in the future, in accordance with the standards of her profession, 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 Eastwind Healing Center's reception desk (337-3313) at least 24 hours in advance. If I miss an appointment without the 24 hour cancellation/notification, I understand that I will be billed $50 for a 30 minute visit or $100 for a 60 minute scheduled visit via email through a Square Invoice and that this charge is not reimbursable by a third party payer.

Payment:

____I understand that this office accepts **Blue Cross Blue Shield** insurance only and that any co-pay is due at time of service. If I do not have this insurance, payments for service are due in full at the time of the appointment per the following fee schedule: 60 min intake/evaluation $200; medication management follow-up visits vary from $90-140 (depending on services provided); follow-up visits that include counseling/therapy range from $85-160 (depending on the amount of time spent in session). If paperwork or form completion are requested other than during scheduled appointments, $25-50 will be billed to me by email through a Square invoice (depending on amount of time in service).

Telephone/Email Contacts and Emergencies:

____I understand that email is not a secure form of communication and that if it is used, confidentiality cannot be guaranteed. Email is only for the convenience of our patients and completely optional. If I request email be used, I am authorizing Dr. Gullickson to use this mode of communication for providing medical information at her discretion or at my specific request and accept the liabilities entailed with this form of communication. I will sign the separate email agreement form before using email communication with Dr. Gullickson.

____I understand that if I leave a message by phone/email for Dr. Gullickson, I may expect a return message within 48 hours during business hours. If she is on leave, medical options for cross-coverage will be provided to me.

____I understand that Dr. Gullickson runs a small medical practice without full after-hour service options. 24-hour access to Dr. Gullickson is not available. I understand that I am responsible for having a primary care physician who is aware of my psychiatric care and medications and can be contacted with medical emergencies. I understand that urgent psychiatric assistance for safety issues can be found at: The Mercy Iowa City Hospital On Call RN Line at 358-2767 or toll-free at 800-358-2767, or the Johnson County Crisis Line at 319-351-0140 or online at http://jccrisiscenter.org/.

____I agree that with an emergency, I will call 9-1-1 or seek attention at my nearest emergency room. I have had an opportunity to discuss all aspects of this agreement with Dr. Gullickson. 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 Dr. Gullickson.

Patient Signature

_____Date_____