LINDA CARLSON SHAW, CNS, NP, APN

BOARD CERTIFIED PSYCHIATRIC NURSE PRACTITIONER

HEALTHCARE PROVIDER – PATIENT SERVICES AGREEMENT

Name_____Date of Birth_____

Welcome, I am pleased you have chosen me as your healthcare provider. Please read the following document carefully as it contains important information about my professional services and practice policies.

MEDICATION SERVICES

Your treatment may include taking medication. There are wide varieties of medications available for sleep or sleepiness problems as well as for mental health problems such as depression or other mood disorders like bipolar disorder, anxiety, post-traumatic stress disorder, psychotic disorders and others. Prescribing of medication must take into account your personal medical history, other medications that you take, allergies to medicines or other products and your treatment goals. When I recommend a medication prescription for you, I will inform you of significant benefits and risks, answer any of your questions to the best of my ability and advise you about appropriate regular monitoring of your use of medication, including any necessary periodic laboratory tests.

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CONTACTING ME

My office phone number is 970-456-6354. Due to my work schedule, I am often not immediately available by telephone. When I am temporarily unavailable by telephone, my telephone is answered by an answering service. I will make every effort to return your call promptly during business hours. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your primary care physician or the nearest emergency room or dial 911. In all instances, if you feel you have a life threatening medical emergency, call 911, or go to your nearest emergency room.

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LEGAL LIMITS ON CONFIDENTIALITY PROTECTIONS

The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPAA). There are other situations that require only that you provide written, advance consent. However, there are some situations in which I am permitted or ***required*** to disclose information without either your consent or Authorization. These situations are primarily related to danger to yourself or to others and child or elder abuse and neglect. If such situations arise, I will make every effort to discuss them with you before taking any action and I will limit my disclosure to what is necessary. Your signature

on this Agreement provides consent for those activities. While this written summary or exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and I do not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

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PROFESSIONAL RECORDS

You should be aware that, pursuant to the Health Information Portability and Accountability Act (HIPAA), I keep Protected Health Information (PHI) about you currently in a secure, written file.

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PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to or authorized; determining locations to which PHI disclosures were sent; having any complaints you make about my policies and procedures recorded in your records; an d the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

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CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that Linda Carlson Shaw, CNS, NP, APN, carry out behavioral health treatments, such as referrals for annual labs, or blood levels on certain medications, now or during the course of my care are advisable. I understand that the purpose of these practices will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Patient or (Authorized Guardian Name) **Printed**

Date

Patient or (Authorized Guardian Name) **Signature**

Date