TFCPC Pearls of Wisdom Covenant Agreement

Please read the following pearls very closely and in entirety before signing…

1. I will immediately notify The Fort Christian Psychiatric Center (TFCPC) / Dr. Fortuchang if there are any significant changes in psychiatric symptoms and/or medical condition (pregnancy, etc.).

2. If I have thoughts of hurting myself, I will notify Dr. Fortuchang immediately. If I am suicidal or have a medical emergency requiring immediate action, I will call 911 or go to the nearest ER and contact Dr. Fortuchang afterward.

3. If I ever require emergent psychiatric treatment and/or hospitalization, I will make sure that Dr. Fortuchang is promptly notified. I will call TFCPC on the next business day to schedule an urgent follow-up appointment. I will inform Dr. Fortuchang of any medication changes made during hospital visit and/or hospitalization.

4. I will take medication as prescribed. If I want to increase, decrease, or discontinue medication, I will discuss with Dr. Fortuchang first. I understand that making changes without Dr. Fortuchang's permission and guidance is strictly prohibited, potentially dangerous and will impair my standing as a patient at TFCPC.

5. I understand that it is extremely important not to share my medication with anyone, and not to take any medication that has been prescribed to someone else. I understand that such actions are strictly prohibited.

6. I understand that obtaining psychiatric medications from any doctor(s) other than Dr. Fortuchang (except during hospitalization) violates the trust and open communication essential to a functional doctor-patient relationship. Such actions are strictly prohibited and may result in termination from The Fort Christian Psychiatric Center.

7. I understand that it is dangerous to misuse alcohol and prescription medication, or use illegal drugs— especially when taking psychiatric medication. I understand that substance abuse/dependence may result in termination of treatment with referral to an addictions specialist, as Dr. Fortuchang is not an addictions specialist.

8. **I will notify Dr. Fortuchang if there are any changes to my contact information and my credit/debit card on file.**

9. I fully understand that The Fort Christian Psychiatric Center does not engage in email correspondence with patients and/or their families, other than under special circumstances or to send office-wide information.
   ***I will regularly check my email inbox. *I will reply to all emails (& phone messages) requesting a response!**

10. I will not expect to receive any response to any email(s) I choose to send, and I will not send any emails containing urgent/emergent/clinical questions or information regarding the treatment.

11. Because safety is extremely important, I will follow the treatment plan (medication, frequency of appointments, etc.) outlined by Dr. Fortuchang. I will ask questions whenever I do not understand something about the treatment.

12. I understand that it is my responsibility to keep track of my medication and request medication refills during my appointment. I am fully aware that refill requests made between appointments are subject to a $25 fee.

13. I agree not to take any over-the-counter supplements (diet pills, herbal supplements, etc)—especially if I'm being prescribed medication, without first discussing it with Dr. Fortuchang. Such supplements may have adverse effects, may interact with prescribed medication and could worsen certain psychiatric disorders

14. I fully understand that signing this form does not create a doctor-patient relationship between me and Shaw Wendi Fortuchang, M.D., and that it is not until after the initial evaluation when it may be mutually agreed upon to create one.

15. I have read, understand, and agree with the above Pearls of Wisdom and the office policies for TFCPC, and I understand that failure to comply with them could result in termination of my treatment at The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C., once becoming a patient.

Patient's Signature _____ Date _____

Patient's Printed Name _____ Date _____

***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**