Pearls of Wisdom Covenant Agreement

1. I will notify Dr. Fortuchang, immediately, if there are any significant changes in my psychiatric symptoms and/or medical condition (pregnancy, etc.).

2. If I feel that I am at risk of hurting myself, I will notify Dr. Fortuchang immediately. If I feel that I am at imminent risk and need immediate attention, I will call 911 or go to the nearest emergency room.

3. If I ever end up requiring emergent psychiatric treatment and/or hospitalization, I will see to it that Dr. Fortuchang is notified within 24 hours. Afterward, I will follow-up with the office on the next business day to schedule an appointment. I will also inform Dr. Fortuchang of any medication changes made at the hospital.

4. I will take my medication as prescribed. If I want to increase, decrease, or discontinue my medication, I will discuss with Dr. Fortuchang first. I understand that changes made without Dr. Fortuchang's permission is strictly prohibited, potentially dangerous and will negatively affect my standing as a patient at The Fort Christian Psychiatric Center.

5. I understand that it is extremely important not to share my medication with anyone else, as well as 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 violates the trust and open communication essential to a healthy therapeutic relationship. Therefore, such actions are strictly prohibited and may result in termination from The Fort Christian Psychiatric Center.

7. I understand that it is strongly advised to not drink alcohol or use illegal drugs— especially while taking psychiatric medications. I understand that substance abuse/dependence may result in termination of treatment and referral to an addictions specialist. I am aware that Dr. Fortuchang is NOT an addictions specialist.

8. I will notify Dr. Fortuchang if there are any changes to my home address, phone number or e-mail address.

9. I fully understand that The Fort Christian Psychiatric Center does not engage in email correspondence with patients and/or their families. Therefore, 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 my treatment.

10. Because safety is paramount, I will strictly adhere to the treatment plan (medication, frequency of appointments, etc.) prescribed by Dr. Fortuchang, and I will ask questions when I do not understand something regarding my psychiatric treatment.

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

12. I have read the office policies for The Fort Christian Psychiatric Center in their entirety. I understand them, I agree with them, and I understand that failure to adhere to them may result in termination of my treatment.

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 and may worsen certain psychiatric disorders. I understand that failure to adhere to this pearl could jeopardize my status as a patient at The Fort Christian Psychiatric Center.

14. I understand that failure to adhere to these pearls of wisdom could result in my termination from The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C.

I have read, understand, and agree with the above Pearls of Wisdom.

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.**