



## TFCPC PEARLS OF WISDOM COVENANT AGREEMENT

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

1. I will notify The Fort Christian Psychiatric Center / Dr. Fortuchang, immediately, if there are any significant changes in my child's psychiatric symptoms and/or medical condition (pregnancy, etc.).
2. If I am concerned that my child is having thoughts of hurting him/herself I will notify Dr. Fortuchang immediately. If my child is suicidal or has a medical emergency needing immediate attention, I will call 911 or go to the nearest ER.
3. If my child ever requires psychiatric treatment in an ER and/or hospitalization, I will make sure that Dr. Fortuchang is notified within 24 hours. 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 the hospital visit and/or hospitalization.
4. My child will take medication as prescribed. If I want to increase, decrease, or discontinue the 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 affect my child's standing as a patient at TFCPC.
5. I understand that it is extremely important for my child not to share his/her medication with anyone, and not to take any medication prescribed to someone else. I understand that such actions are strictly prohibited.
6. I understand that obtaining psychiatric medications for my child 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 TFCPC.
7. I understand that it is dangerous for my child to drink alcohol, misuse 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 child's contact information and 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 extenuating 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, my child and I will follow the treatment plan outlined by Dr. Fortuchang, and I will ask questions when I do not understand something regarding the psychiatric treatment.
12. I understand that it is my responsibility to keep track of my child's medication and request any medication refills during the appointment. I am fully aware that refill requests made between appointments are subject to a \$25 fee.
13. I will not allow my child to take any over-the-counter supplements (diet pills, herbal supplements, etc)—especially if 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 my child 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 child's treatment at The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C., once becoming a patient.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian 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.**