Psychiatric Medication & Therapy Agreement

The purpose of this agreement is to ensure that you are properly addressing your psychiatric issues outside of receiving this prescription from Sarah Mildred Gamble, DO, your designated Primary Care Provider (PCP). Meeting on a regular and routine basis with a Psychotherapy Provider is mandatory.

1. I, _____ agree to meet on a regular and routine basis with a Psychotherapy Provider for the duration I take the medication/medications: _____ prescribed by my PCP- Sarah Mildred Gamble, DO.

2. I agree to communicate fully with my PCP and PP about the character and intensity of my psychiatric symptoms including their effect on my daily life, and how well the medicine is helping to relieve the symptoms at each visit. I will also contact **both** my PCP and PP if I feel an overwhelming and prolonged sense of sadness and helplessness, my emotional difficulties make it hard for me to function from day to day, and my thoughts/actions are harmful to myself or others.

3. I acknowledge that my PCP is not a therapist and is not trained to counsel me for the underlying psychological conditions which necessitated the need for the medications.

4. I resolve not use any illegal substances, use/misuse legal controlled substances, or attempt to obtain any controlled medications from any other physician or health care facility. I understand that the use of alcohol is discouraged by my PCP while undergoing psychiatric treatment.

5. If I undergo PP treatment with a psychiatrist (MD/DO) who wishes to prescribe a different/additional medication than that prescribed by my PCP, I will immediately notify my PCP of the same.

6. I authorize my PCP to provide a copy of this Agreement to my PP and waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

7. I agree to use my medicine at a rate no greater than the prescribed rate, and will not share it with anyone. I agree to follow these guidelines that have been fully explained to me.

8. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my PCP undertakes to treat me based on this Agreement.

9. I understand that if I break this Agreement, my PCP reserves the right to refer me to an alternative PCP for transfer of care and future treatment.

I agree to use: _____ Pharmacy
Located at: _____
Telephone #: _____

Patient Name: _____
Patient Signature: _____

Physician Name: _____
Physician Signature: _____

This agreement is entered into on this _____ day of _____, 201__.