Print Form

SUPPLEMENTAL INFORMED CONSENT FOR PSYCHIATRIC TREATMENT & MEDICATION MANAGEMENT

1. ***SERVICES*** - Psychiatric treatment and medication management are delivered by Independent Contracted Providers including Advanced Practice Registered Nurses with certifications as Board Certified Psychiatric Nurse Practitioners.
2. ***PROFESSIONAL FEES*** - Fees for psychiatric treatment are $250 for an initial diagnostic intake and $200 for a 30-minute medication management appointment. True Joy Counseling and Consulting, PLLC (TJCC) files for PRIMARY INSURANCE as a courtesy and it is no way a guarantee that your insurance company will pay for services rendered. All claims are subject to the conditions of your policy. You, as the patient, are ultimately responsible for your account and any follow-up needed with your insurance carrier as their beneficiary.
3. ***SUPPLEMENTAL INFORMATION*** - This information is specific to psychiatric treatment and medication management and accompanies the general practice information contained in the Letter of Understanding and Informed Consent.

WE LOOK FORWARD TO A SUCCESSFUL THERAPEUTIC RELATIONSHIP WITH YOU.

I certify that I have read and agree to the Supplemental Informed Consent and I, the undersigned party, do hereby give my consent to the TJCC Independent Contracted Provider, in the capacity of psychiatric treatment and medication management.

Electronic Submissions: Typing your name on the signature line below constitutes a legal signature confirming that you accept the agreement and consent above.

Patient's Name _____

Patient's Signature _____ Date _____

Patient is a minor ☐ or is unable to consent because _____.

Parent/Guardian/Responsible Party Name _____ and I have signed this Consent on their behalf.

Parent/Guardian/Responsible Party Signature _____

Please review and complete the following pages 2 - 5.

CURRENT MEDICATIONS & SUPPLEMENTS

Please list *ALL* medications currently prescribed by any medical professional as well as any vitamins and/or supplements.

Medication Name *Example: Prozac*	**Dosage** *Example: 20 mg*	**Times Taken Daily** *Example: Once a day*

PAST PSYCHIATRIC MEDICATIONS

Please list *ALL* past psychiatric medications previously taken.

Medication Name *Example: Prozac*	**Dosage** *Example: 20 mg*	**Length of Time Taken?** *Example: 6 months*	**Why Did You Stop Taking It?** *Example: Made me nauseous*

ALLERGIES

Please list any medication allergies or check the box if you have no known allergies.

☐ I have no known drug allergies.

Medication Name	**Reaction**

PSYCHIATRIC INPATIENT HOSPITALIZATION

Please list the details of any psychiatric inpatient hospitalizations.

Date of Admission	Hospital Name	Reason for Admission

SUBSTANCE USE

Please list *ALL* substances currently being used or used in the past and any associated problems.

Substance	Use	Problems?
Alcohol	☐ Current ☐ Past ☐ How much?	
Caffeine	☐ Current ☐ Past ☐ How much?	
Marijuana *(with or without medical card)*	☐ Current ☐ Past ☐ How much?	
Narcotics/Controlled Substances	☐ Current ☐ Past ☐ How much?	
Nicotine	☐ Current ☐ Past ☐ How much?	
Other:	☐ Current ☐ Past ☐ How much?	
Other:	☐ Current ☐ Past ☐ How much?	

MEDICAL HISTORY / CHANGES / MEDICAL TEAM

Please circle any condition below that applies to you and briefly explain.

ADHD	Alcohol/Drug Abuse	Alzheimer's
Anxiety	Cancer	Chronic Pain
Depression	Diabetes	Fibromyalgia
Gastro Esophageal Reflex (GERD)	Head Injury	Heart Disease
High Cholesterol	Hypertension	IBS
Kidney Disease	Migraines	Parkinson's
Seizures	Sleep Apnea	Stroke
Surgery	Thyroid (Hyper/Hypo)	Other:
Please list any recent changes you have in the following areas.		
Ability to Sleep	Energy Level	Weight
Blood work/Labs	Blood work/Labs	Blood work/Labs
Please list the physicians on your medical team and their specialties.		

FAMILY HISTORY

Please place a check mark to indicate any family member that have or have had any of the following conditions.

	Mother	Father	Daughters	Sons	Sisters	Brothers	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
ADHD												
Alcohol/Drug Abuse												
Alzheimer's												
Anxiety												
Cancer												
Chronic Pain												
Depression												
Diabetes												
Fibromyalgia												
Gastro Esophageal Reflex GERD)												
Head Injury												
Heart Disease												
High Cholesterol												
Hypertension												
IBS												
Kidney Disease												
Migraines												
Parkinson's												
Psychiatric Disorders												
Seizures												
Sleep Apnea												
Stroke												
Thyroid (Hyper/Hypo)												
Other:												
Other:												
Please complete the following information for each family member listed above.												
Living or Deceased (*L / D*)												
Age at Death if Deceased												

Please provide any other additional details.

CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to prevent any misunderstandings regarding controlled substances that the Independent Contracted Advanced Practice Registered Nurse at this Practice may prescribe you. The aim is to treat you safely and also to prevent abuse or addiction to these types of medications. Because these controlled pharmaceuticals have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following policies are agreed to by you, the patient, to help maintain safety and provide quality, effective psychiatric care.

- ✓ I will communicate openly and honestly with my prescriber about the intensity and characteristics of my symptoms, the impact of the symptoms on my daily life, and how well the medication is helping to relieve my symptoms.
- ✓ I understand my prescriber is bound by law to access my controlled substances report through E-FORCSE, Florida's Prescription Drug Monitoring Program databank, before any controlled substance prescription is written for me.
- ✓ I am responsible for my medications; I will not share, sell, or trade my medication.
- ✓ I will not increase my medication dose or use until I speak with my Provider. If I do so on my own, I understand that use of medication at a greater rate than prescribed may result in me being without medication for a period of time.
- ✓ I will safeguard my medication from loss or theft. I understand that the medication may not be replaced if it is lost, stolen, or consumed earlier than the actual refillable date, and early refills may not be granted by pharmacies in spite of written request/permission by the prescriber.
- ✓ I agree that renewals and refills of my prescriptions for controlled medications will only be made at the time of a scheduled appointment and/or during regular office hours. No refills will be available before or after office hours, during evenings, over weekends, or during holidays.
- ✓ I agree to voluntary blood and/or urine testing before initiating treatment and randomly if requested by my prescriber to determine my compliance with my controlled pharmaceuticals. I understand and agree to this even if these tests are not covered by my insurance company/policy.
- ✓ I will not use any illegal controlled substances including marijuana, cocaine, ecstasy, etc. I understand I may be referred for addiction treatment and possibly tapered and/or discontinued from the controlled substance immediately or in the future in the presence or absence of unauthorized or illicit substances.
- ✓ I will not attempt to obtain controlled medications from any other prescriber to treat the same symptoms for which I am receiving treatment at this Practice.
- ✓ I will exercise extreme caution when taking these medications and driving or operating heavy machinery. I understand the use of these medications may induce drowsiness or change mental abilities, thereby making it unsafe to drive or operate heavy machinery.
- ✓ **I agree to use _____ (Pharmacy), located at _____ (Address) to fill all of my prescriptions written by my provider at True Joy Counseling and Consulting, PLLC.**
- ✓ I agree to notify my prescriber and/or their staff if I change my pharmacy and I agree to use the same pharmacy for fill all my prescriptions.
- ✓ I authorize my prescriber and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, or other diversion of my medication. I authorize my prescriber to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- ✓ I understand that this Agreement is vital to the trust and confidence in my prescriber and patient relationship and that my prescriber relies on this Agreement when engaging my psychiatric treatment.
- ✓ I understand that if I breach this Agreement, my prescriber may stop prescribing me certain medications and/or release me from their care and practice. In this case my provider will taper me off the medication over a period of time, as necessary, to avoid withdrawal symptoms. Additionally, a drug dependency program may be recommended.

I certify that I have read and agree to the Controlled Substance Agreement and I, the undersigned party, do hereby give my agreement to the TJCC Independent Contracted Provider, in the capacity of psychiatric treatment and medication management.

Electronic Submissions: Typing your name on the signature line below constitutes a legal signature confirming that you accept the agreement and consent above.

Patient's Name _____ Patient's Signature _____ Date _____

Patient is a minor ☐ or is unable to consent because _____.

Parent/Guardian/Responsible Party Name _____ and I have signed this Consent on their behalf.

Parent/Guardian/Responsible Party Signature _____