HEALTHY MINDS FOR HEALTHY LIVES

Merrill Wood DNP, APRN, CPNP-PC, PMHS, BICBT-CC
www.healthymindsforhealthylives.com
admin@healthymindsforhealthylives.com
940-757-1943

Patient Agreement Form

AGREEMENT FOR LONG TERM PRESCRIPTIONS

We appreciate your business and we look forward to continuing to work with you and your child in their treatment for anxiety or depression. To best serve you, it is important to renew our agreement regarding services provided. In signing this consent, I, _____ (parent/guardian) agree to the following therapeutic requirements that are designed to help my child, _____in advance.

Client's responsibilities

1. I will keep appointments with professionals involved in mine or my child's care. If me/my child is working with Dr. Merrill Wood and is prescribed medication, I agree that my child will take medications as prescribed.
2. I agree that I will keep regular appointments for medication management and me/my child will be seen at least monthly for 3 months and then at least every 3 months once me/my child is on a dose determined to be effective.

Patient Name:_____ Date:_____

Guardian Signature:_____ Date:_____

Kindly,
Dr. Merrill Wood, DNP, CPNP-PC, PMHS, BICBT-CC