LumenMind
PSYCHIATRY
Holistic Mental Wellness

LumenMind Psychiatry, LLC
Pennsylvania Telehealth
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Medical Waiver Form

Patient Information

Name _____ **Date of Birth** _____

Address

_____

Phone Number _____ **Email** _____

Medical History

Please indicate any existing medical conditions and provide details regarding your cardiac history.

☐ Cardiomyopathy ☐ Arrhythmias ☐ Hypertension

☐ Heart Valve Disorders ☐ Coronary Artery Disease ☐ Other _____

Details

_____

Medication Information

Are you currently taking any medications for your cardiac condition? If yes, please list:

_____

Acknowledgement and Waiver

I, _____ (patient name), understand that I have a history of cardiac issues, and that taking a stimulant medication such as Adderall may have implications for my cardiovascular health. I acknowledge that the prescribing provider at LumenMind Psychiatry, LLC has discussed the risks and benefits of stimulant treatment with me, including the potential exacerbation of cardiac symptoms or complications.

I understand that it is important to monitor my cardiac health closely while taking this medication, and I agree to comply with all recommended medical evaluations, including regular cardiac assessments and follow-up appointments. I understand that I should promptly report any new or worsening symptoms related to my cardiac health to my healthcare provider.

I acknowledge that I have been provided with information about alternative treatment options for managing my symptoms and that I have chosen to proceed with this treatment despite the potential risks to my cardiac health. I understand that this decision is made in consultation with my healthcare provider and is based on an assessment of my individual medical history and treatment goals.

I hereby release LumenMind Psychiatry, LLC and its healthcare providers from any liability related to the use of this medication in the context of my cardiac history. I understand the potential risks involved and agree to assume responsibility for my health and well-being while undergoing this treatment.

Patient's Signature _____ **Date** _____

Parent / Guardian Signature (if patient is a minor) **Date** _____

_____

Provider's Signature _____ **Date** _____

Please retain a copy of this waiver for your records. If you have any questions or concerns, please do not hesitate to contact us at LumenMind Psychiatry, LLC.

This is a liability waiver involving medical risk. It is a starting template and must be reviewed by the prescribing provider and the practice's counsel before use.