KETAMINE HEALTH &
RESTORATION

Consent for Treatment

This informed consent ("Informed Consent") governs my care by **Ketamine Health & Restoration**.

I understand that I am seeking treatment from **Ketamine Health & Restoration**. Accordingly, I hereby authorize and consent to the administration of all diagnostic procedures and/or any assessment measures that are part of **Ketamine Health & Restoration**'s evaluation of me.

I understand that after this evaluation and any possible diagnostic test results ordered by **Ketamine Health & Restoration**, **Ketamine Health & Restoration** may recommend certain treatments and/or higher levels of care. I understand that I have the right to be informed of the various steps and activities involved in the care that I receive from **Ketamine Health & Restoration**.

I understand that I have the right to make an informed decision on whether to accept or refuse **Ketamine Health & Restoration**'s suggestions. I understand that I may revoke my consent to treatment at any time except to the extent that **Ketamine Health & Restoration** has already rendered such treatment.

I understand that in certain situations only as mandated by state and local laws, without the consent of the patient or parent/legal guardian, **Ketamine Health & Restoration** is required to report all cases of abuse or neglect of minors or certain vulnerable adults.

I understand that state and local laws permit **Ketamine Health & Restoration** to report to a designated agency any case in which he believes in good faith that there is an imminent risk of danger to a patient or other person (e.g., potential for suicide or homicide). I also understand that if a patient communicates a threat to harm another person, Ketamine Health & Restoration, is required to warn the potential victim and notify the police. Additionally, if a judge orders the release of medical records by court order, Ketamine Health & Restoration may be required to release confidential information.

I understand that treatment involves lifestyle changes, the learning of new skills, and consistent investment of time, effort, and practice.

I understand that patients often see the best results and improvements, including maintenance of these changes, when a patient incorporates and frequently reinforces such changes, especially in the beginning stages of treatment. Moreover, I understand that I should make efforts to make and keep appointments and to be consistently ready and motivated.

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I understand that during the course of my treatment, I may discuss the material with **Ketamine Health & Restoration** that may be upsetting in nature and that this may be necessary to help me feel better.
I understand that it is my responsibility to monitor the subjective effects of treatment and to continue treatment so long as I perceive there is still a benefit.

I understand that different individuals progress with treatment at different rates and with different styles and that the research literature indicates that there are some individuals who are apparently unaffected by treatment. Accordingly, I understand that I am encouraged to evaluate my progress after approximately six (6) months to determine, in conjunction with **Ketamine Health & Restoration**, whether further treatment is indicated.

I am encouraged to discuss the factors contributing to my concern or decision with him. I understand that my feedback is essential for promoting and ensuring the quality of care and service that I receive.

I understand that if my condition deteriorates or other difficulties arise that are beyond the competency and training, experience, or resources of **Ketamine Health & Restoration**, then **Ketamine Health & Restoration** will work with me to find a more fitting method of treatment and will refer me to another provider, as deemed appropriate.

By signing this form, I indicate my understanding of the principles and policies set forth herein in this Informed Consent.

I have read and understood this document in its entirety and have had the opportunity to have my questions answered to my satisfaction.

PATIENT SIGNATURE: _____
PATIENT NAME: _____
DATE: _____
TIME: _____