

Iowa Ketamine Services, PLC

Ketamine Infusion Registration

Name: _____ DOB: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Can we leave messages on your phone? Primary Y____ N____

Secondary Y____ N____

Email: _____

Receive reminders via Phone? _____ Email? _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Can the person above receive medical information about you?

Primary Care Physician: _____

Secondary Physician: _____

May we share your health information with the above physicians? Y____ N____

Is there anyone else who can receive medical information about you? If so, please list name and phone number: _____

Who can we thank for referring you? _____

OFFICE POLICIES

Read and initial where indicated.

- We hold your privacy in the utmost importance and will not share your protected health information without express written permission from you.
- Payment is due at the time of services rendered, we take cash or credit card. **Please initial__**
- We do not bill insurance. At your request, we will provide you with a superbill that you can submit back to your insurance company for possible reimbursement.

- We are available by phone 24/7 and respect that you will only call in case of an urgent/emergent need. However, if you feel you may have a life-threatening issue, please call 911. **Please initial _____**
- We reserve the right to re-schedule or cancel your appointment if you are more than 15 minutes late. Please see cancellation/no-show policy for full details.
- It is essential that you continue to maintain a primary treatment relationship with your current psychiatrist or primary care physician, and will follow-up with that person on an on-going basis after completion of your ketamine treatment. *All medication changes should be done under their supervision.* **Please initial _____**
- We will not write refill prescriptions for chronic medications.
- We will gladly provide you a consult letter that discusses your treatment course here at no cost.
- *We will not complete disability or referral paperwork.* **Please initial _____**
- All patients must have a driver. We reserve the right to cancel treatments if no driver has been arranged for your ride home. **Please initial _____**
- Ketamine treatment is an evolving science. We pledge to stay knowledgeable on current best-practices in this field.

I have read the above statements. I understand and agree with the policies.

Signature _____ Date _____

