IOWA KETAMINE SERVICES PLC

Financial Agreement

Mental Health: Refractory Depression, PTSD, OCD, Anxiety

- $425.00 per infusion
- Initial protocol is 6 infusions over 2-4 weeks ($2550.00 total)
- "Booster" doses are scheduled on an as-needed basis and consist of only 1 infusion (no need to repeat the six loading doses).

Pain Infusions

- $1100.00 per infusion
- Protocol is daily infusions for 5 days ($5500.00 total)
- Infusions are 4 hours in length
- "Booster" doses are scheduled on an as-needed basis and consist of 1-2 infusions.

What is included:

- All medications required to treat side effects of ketamine: nausea, anxiety, hallucinations, etc
- Medications that may be used to augment effectiveness of ketamine (ie – magnesium)
- Monitoring by a physician at all times, no techs or other office staff
- Office will be closed to other patients during your infusion. Doors will be locked.
- Television with Netflix and Amazon Prime
- Comfortable waiting area for your driver or support person

Forms of payment accepted:

- Credit cards/Debit Cards
- Care Credit
- Cash
- Please check with your Flex Spending or HSA accounts to verify coverage of the infusions

I, ____, have read the pricing agreement and understand the following:

- My infusions may or may not be reimbursable by my health insurance
- Payment is required prior to the infusion starting.
- Once the infusion has started, no refunds are given even if the infusion has to be stopped by the physician or patient.
- There is no guarantee ketamine will be effective for my symptoms and I will not be refunded if this treatment is not successful.
- I will be charged the full infusion cost if I do not show up to my visit without at least a 4-hour cancellation notice.
- A valid credit card will be kept on file but *only used if the no-show/cancellation policy has been violated, or if I ask the clinic to run my card to pay for infusion.*

Credit Card Information:

- Name on card: ___________________________________
- Card type & number: ____________________________
- Expiration date: _________________________________
- Security number: ________________________________
- Zip Code: _______________________________________

Patient Name: _______________________________ Signature: _________________________________

Date: ______________________ Witness Signature: ____