Financial Responsibility

West Michigan Ketamine Clinics appreciate the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, requires a financial responsibility on your part. The responsibility obligates you to ensure your payment in full of our fees. Insurance coverage has not been approved yet, but we have seen some insurances cover a small percentage of the cost of treatment. Many insurance companies have additional stipulations that may affect your coverage. It is the patient's responsibility to know your coverage benefits. You are responsible for the full cost of infusions at time of visit. If your insurance will allow for reimbursement, please contact the office at 616-828-3899 for an itemized receipt of any infusions completed.

A $50 cancellation fee will be collected at time of visit if patient no shows, is late and has to reschedule, or cancels appointment after it has been confirmed. A credit or debit card information will be taken down at time of scheduling. Patients will be notified first if the card will be used. The card will only be used if patients no show, are late and have to reschedule, or cancels after appointment has been confirmed.

Late Policy: if you are 15 minutes late you are in jeopardy of needing to reschedule. If you are 30 minutes late or more you will have to reschedule and pay the cancellation fee.

A one time only $50 setup fee that will apply to all patients for medical records to be updated or created in our new electronic system. New patients will have that fee taken from the cost of their first appointment, with the remaining balance of $550 be due at time of visit in office. Established patients will have that fee applied with their first appointment back with us for a total of $550. All other infusions for all patients will cost $500.

Patients who may wish to pay in full before the appointment may do so as well.
**NOTICE: If using a credit or debit card, there may be a 3.5% service fee charged at time of payment.

<u>Consent for treatment and authorization to release information</u>

I hereby authorize West Michigan Ketamine Clinics, through its appropriate personnel, to perform or have performed upon me appropriate assessment and treatment procedures.
I hereby authorize West Michigan Ketamine Clinics, to release to appropriate agencies, any information acquired in the course of my examination and treatment.

_____ _____

Patient Signature -or-
Parent/legal gaurdian

Date