NEUROHAVEN

Phone: (725) 217-3519
Fax: (725) 348-0846
E-mail: Info@neurohavenmhc.com

Informed Consent for Ketamine Infusion Therapy

Ketamine is approved by the FDA for use in children and adults for anesthesia and as a pain reliever during medical procedures. When administered in a low-dose infusion, ketamine is a medication that may provide relief of symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), acute and chronic pain. Ketamine's use for treatment of pain, depression or other mental illnesses is off-label. Off-label use of medications is legal and very common. In fact, about one in five prescriptions written in the US today is off-label.

Why Is Ketamine Being Recommended?
Numerous studies show that ketamine may be helpful in the treatment of depression, anxiety, PTSD, acute and chronic pain. When administered by vein over a period of 40 minutes up to an hour (called an infusion), ketamine may help improve symptoms rather quickly. Improvements may last several days up to a few months. A series of infusions is recommended so that symptom relief has a longer duration of action. While the goal is improvement of symptoms, individual results cannot be guaranteed.

What Will Be Done?
You will be receiving ketamine by IV Infusion. This means an IV catheter will be inserted into a vein of your hand or arm and a ketamine fluid will be dripped into the vein. During the infusion your level of sedation, blood pressure, heart rate, oxygen concentration, heart rhythm and respirations will be monitored. After the treatment, you will need time to recover in the office and may take some sips of fluid during the recovery period. For depression, current research recommends that you receive 6 treatments over about two weeks as the primary treatment episode. Additional maintenance treatments may or may not be suggested, occurring about once a month or less frequently as recommended by your infusion provider. For pain, the frequency of Ketamine infusions is based on your specific type of pain and response to therapy.

What Safety Precautions Must You Take?

- You may not eat or drink 6 hours before the infusion, water is the only exception. You may drink water up to 2 hours before the infusions.
- You may NOT drive a car, operate hazardous equipment, or engage in hazardous activities for at least 24 hours after each treatment as reflexes may be slow or impaired. Another adult will need to drive you home and must be present prior to your discharge.
- You must refrain from alcohol 24 hours prior-to and following ketamine administration. You must refrain from other illegal substances during your ketamine infusion treatment.
- You must tell the clinic about all medications you are taking, especially narcotic pain relievers, benzodiazepines, barbiturates and muscle relaxers.
- To qualify to receive ketamine therapy for mental health conditions, you must notify and share the contact information for the mental health provider treating your psychiatric symptoms or your current primary care provider.
- If you experience a minor side effect while you are at home, you should contact NeuroHaven MHC (725-217-3519) otherwise contact your medical provider or call 911.

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What Are the Possible Side Effects of Ketamine?
Possible side effects may include and are not limited to:

- fast or irregular heart beats
- increased or decreased blood pressure
- vivid dreams
- confusion
- irritation or excitement
- floating sensation ("out-of-body")
- twitching, muscle jerks, and muscle tension
- confusion
- urinary frequency
- increased saliva or thirst
- lack of appetite
- headaches
- metallic taste
- constipation
- blurry or double vision
- nausea or vomiting
- memory changes

Rare side effects of ketamine are:

- allergic reactions
- pain at site of injection
- increase in pressure inside the eye
- inflammation in the bladder
- respiratory complications
- hallucinations
- euphoria
- involuntary eye movements
- low mood or suicidal thoughts

Side effects of receiving an IV are:

- mild discomfort at the site of placement
- bruising
- infiltration
- infection

Important Notices and Agreements:

- KETAMINE INFUSION THERAPY IS NOT A COMPREHENSIVE TREATMENT FOR DEPRESSION, ANXIETY OR ANY PSYCHIATRIC SYMPTOMS
  Your ketamine infusions are meant to augment (add on to, not be used in place of) comprehensive psychiatric treatment. Therapy is a recommended adjunct. Initial _____

- While receiving ketamine infusions, you agree to remain under the care of a qualified primary care or mental health provider and have your overall health care directed by him or her. Initial _____

- Psychiatric illnesses carry the risk of suicidal ideation (thoughts of ending one's life) or thoughts of harming others. Any such thoughts you may have at any time during your ketamine infusion therapy, or at any point in the future, which cannot immediately be addressed by visiting with a mental health professional should prompt you to seek emergency care at an ER or to call 911. Initial _____

- Ketamine use during pregnancy is not generally recommended. Females will be asked to submit a urine sample for a pregnancy test prior to your first infusion and every 2 weeks thereafter. Initial _____

My Consent for Ketamine Treatment is Voluntary:
My request for ketamine infusion treatments as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse ketamine treatments at any time. Any money I have deposited

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for future treatments will be refunded to me if I choose not to proceed with future infusions. I have been advised that I can seek a second opinion from another provider before agreeing to have ketamine treatment and I am choosing to proceed at this time, with or without this second opinion. I have notified my mental health provider and/or primary care provider of my ketamine infusion therapy. Initial _____

Statement of Person Giving Informed Consent

- I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction.
- I have had the opportunity to ask questions about this procedure. I consent and would like to proceed with ketamine infusion treatment.

_____ _____ _____
Signature of Patient Date Time

_____ _____ _____
Signature of Witness Date Time

The provider treating my symptoms of depression or anxiety or other psychiatric symptoms is:

_Nathalie Salafranca, APRN_____
Name of Provider

____725) 217-3519_____ _____(725) 348-0846
Phone Fax

___8905 W Post Rd Ste 110, Las Vegas, NV 89148_____
Address

_____Info@neurohavenmhc.com_____
Email

RELEASE OF MEDICAL INFORMATION
In case of emergency, I hereby authorize my ketamine provider to disclose my medical records, to EMS and to the individual listed above or the appropriate personnel in his or her office. I further authorize the individual listed above to disclose my medical records, including any history of substance use or abuse, to my ketamine provider, or appropriate personnel in his or her office. I also authorize my ketamine provider to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns.

_____ _____
Signature of Patient Date

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FINANCIAL RESPONSIBILITY

I understand that NeuroHaven does not accept insurance. Upon request, I will be given a receipt that I may submit to my insurance for possible reimbursement. I understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed the entire amount of the appointment. I have been given the opportunity to ask questions regarding this statement.

Each treatment balance must be paid in full before we will initiate treatment.

_____	_____	_____
Signature of Responsible Party	Printed Name	Date

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Practice Policies

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:
    a) If ketamine is an appropriate treatment option
    b) Frequency of ketamine infusion sessions
    c) Goals of therapy (what you hope to gain from this process)

2. APPOINTMENTS: Each appointment varies in length depending on your chief complaint. Typically, 45 min infusion appointments take just under 2 hours. At the end of each appointment, you can make arrangements for your next appointment or you may also book all your prescribed appointments at once.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. LATE APPOINTMENTS: If you are more than 30 min late for your scheduled appointment, your session will be cancelled, unless you contact us to arrange a new arrival time.

5. PAYMENTS: Payment will need to be paid in full prior to the start of your appointment.

6. INSURANCE: Insurance is an agreement between you and your insurance company as to how treatment will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in by giving you receipts to submit, and follow up contacts. Some insurance companies will pay for a portion of outpatient ketamine infusion services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through NeuroHaven MHC are ultimately your responsibility. If your insurance company requires that outpatient ketamine infusion services be preauthorized, it is your

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responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party “gatekeeper”. Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

7. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at NeuroHaven MHC and is considered confidential within the office unless specified by you in writing. However, each provider at this office reserves the right to use specialty consultation with other medical providers at the office as deemed necessary. We follow HIPAA and maintain confidentiality.

Please check and initial boxes.

☐ Yes	☐ No	I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.
☐ Yes	☐ No	I have received a copy of the Privacy Practices Form.
☐ Yes	☐ No	I consent to the exchange of treatment information between NeuroHaven MHC and my primary care or mental health provider.

_____ _____ _____
Patient Signature Print Name Date

Nathalie Salafranca, APRN
Provider Name

_8905 W Post Rd Ste 110, Las Vegas, NV 89148_____
Office Address

_725) 217-3519___
Phone Number

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Medical Information Release Form

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards.

Date: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

Release of Information

[ ] I authorize the release of my **medical records**. This information may be released to:

Name of Physician or Provider: _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in the writing. We take your privacy seriously, this information will only be released to the physician or provider listed above.

COMMENTS:

_____

_____

_____

_____