PATIENT CONSENT FORM

PHYSICIAN COUNSELING:
I have received counseling from the physician administering this treatment and am willing to take it as directed and under the physician's supervision.

FDA APPROVAL STATUS:
I understand that the treatment I will be receiving may have not been approved by the FDA to treat my condition.

OFF-LABEL AND NO-LABEL USE:
I understand that the prescribing of this medication and my use of it is either an off-label (non-FDA approved) use of this medication or that the medication does not have an approved use by the FDA. Off-label use of this medication means that the FDA has not approved the use of this medication for the purposes for which the doctor has prescribed it to me. Even though long-term effects of ketamine use have not been researched extensively, limited data suggests instances of cognitive impairment and bladder dysfunction associated with repeated administration of ketamine in rodent models and in humans with ketamine use disorder.

FINANCIAL RESPONSIBILITY:
I understand that I am responsible for all charges for the medication prescribed to me and that the medication will not be provided to me until payment has been made. I am aware that this is the case not only for the initial prescription but also for any refills the physician may have prescribed. I understand that I may be contacted by an agent from my physician's office or a qualified third party to facilitate payment.

GENERAL PROVISIONS:
I acknowledge that the prescribing physician may use and disclose my information as necessary for the purposes of treatment, payment, and healthcare operations. This shall be done in a manner consistent with HIPAA regulations and applicable requirements.

I intend this consent to be continuing in nature and that it will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

I have read or have had read to me all of the above statements and understand them. I have had the opportunity to ask any questions I might have about the medication and the treatment being prescribed, any potential risks, and the alternatives prior to my informed consent. I give consent for this medication/treatment to be prescribed to me and for my use of it as directed by my physician.

Patient Signature:_____ Date: _____

Patient Name (please print): _____