Patient Assessment Form

Name:(Last, First) ____

Email: ____

Address: ____

____

Phone: () ______________________________**Date of Birth**: _____/_____/_________

Height:__________ **Weight**:___________

Referring Provider: __________________________**Specialty**: _______________________

Telephone Number: __________________________

Current Medication(s): ____

____

____

____

Do you have any medication allergies? Yes / No (If Yes, List):

____

____

____

Have you had any Anesthesia Problems with you or your immediate family members? Yes/No
If yes list problems:

____

____

Are you pregnant (or is there any possibility) or breastfeeding? (Females)? Yes / No

Have you been diagnosed with high blood pressure? Yes / No

Have you been diagnosed with a heart or lung disease or condition? Yes / No (if yes, List):

____

Have you been diagnosed with any neurological conditions? (Stroke, Migraine Headaches, Epilepsy, Concussions) Yes/No (If yes, List) ____

____

Do you have Glaucoma? Yes/No

Tobacco Use
Do you currently use Tobacco products? Yes / No

Alcohol Use
Do you currently consume alcoholic beverages? Yes / No

Have you ever had a history of drug or alcohol abuse? Yes / No

Do you have any other medical problems that have been diagnosed or treated?
Yes/No (If yes, list): ____

____

List any **SURGERY(S)** you have had:

Type	Date	Outcome

Have you been diagnosed with any of the following? (Circle):
Depression
Post-Traumatic Stress Disorder
Schizophrenia
Obsessive-compulsive disorder
Generalized Anxiety Disorder
Bipolar Disorder
Drug or Alcohol Dependency
Fibromyalgia
Migraines or daily headaches
Sleep Apnea
Cancer
Reflex Sympathetic Dystrophy (RSD) or Complex Regional Pain Syndrome (CRPS)
(other): ____

Have you ever been treated at an inpatient facility for any of the above diagnosis?
Yes/No (if yes, which facility/dates) ____

Do you have a family history of psychiatric disorders and/or chemical dependency?
Yes/No (If yes, list)

____
____
____
____

Have you ever been treated with electroconvulsive therapy (ECT)? Yes/No

Please add any other pertinent personal or family health information here:

____
____
____
____
____
____

Work Status

Occupation ____

Full Duty   Light Duty   Off Duty per Physician   Unemployed   Retired

If you are NOT working full duty, how long have you been off work?

__________________________   Are you disabled through Social Security? Yes / No

Personal & Lifestyle

Marriage Status _____________

Emergency Contact name/ Relationship _____________________________________
Emergency Contact Phone ____

I attest that the above personal health information is correct and complete:

Signed: ____ Date: ___/___/_____

Informed Consent for Ketamine Infusion

Patient Name: ___________________________

Before you decide to take part in this procedure, it is important for you to know why it is being done and what it will involve. This includes any potential risks to you, as well as any potential benefits you might receive.

Please read the information below closely and ask one of the clinical staff if there is anything that is not clear or if you would like more information. If you do decide to take part, your signature on this consent form will show that you have received all of the information below, that you were able to discuss any questions and concerns you had with a member of the staff, and that you consent to treatment by Elev8 MD Wellness Center, including any and all repeated Ketamine infusions.

Ketamine is widely used in emergency departments and operating rooms on a daily basis for the purposes of surgical sedation and pain control. **Ketamine has not been approved by the Food and Drug Administration (FDA) to treat depression. This is not a research study but is rather a clinical procedure. This procedure is not being monitored by the Institutional Review Board (IRB) or FDA.**

A. Procedures

An intravenous line (IV) will be started in an extremity so that you can receive Ketamine. Your blood pressure, heart rate, and oxygen saturation will all be monitored throughout the infusion under the supervision of a physician, CRNA (Certified Nurse Anesthetist) or RN (Registered Nurse).

Under the supervision of a physician, you will receive ketamine through a vein in your arm or hand. The dose you receive will be determined by the physician or CNRA based on your circumstances and in accordance with the protocol. For the treatment of depression, patients most commonly receive between 0.5 mg to 2.0 mg of Ketamine per kilogram over approximately 40 to 60 minutes, followed by a 20 to 40 minute recovery time. For the treatment of chronic pain, patients most commonly receive between 50 to

100 mg of Ketamine per hour for a time frame of three to four hours, followed by a 1 to 2-hour recovery time.

You will be closely monitored after your procedure and will then be released into the care of a family member or friend once discharge criteria have been met. <u>You cannot drive home after the procedure and should not make important decisions or operate machinery inclusive of a vehicle for the rest of the day or sign any binding legal documents.</u>

B. Risks of Ketamine Infusion

Off-Label Use

Before a drug can be approved, a company must submit clinical data and other information to the Food and Drug Administration ("FDA") for review. The company must show that the drug is safe and effective for its intended uses. "Safe" does not mean that the drug has no side effects. Instead, it means the FDA has determined the benefits of using the drug for a particular use outweigh the potential risks. Once a drug has been approved by the FDA for one purpose, healthcare providers may generally prescribe that drug for other purposes when they judge that it is medically appropriate for their patient. The practice of prescribing a drug for a purpose other than that for which it is approved is known as "off-label" use.

Ketamine has not been approved by the FDA to treat depression or other mental health disorders. Ketamine has not been approved by the FDA to treat chronic pain disorders. IV Ketamine Infusion for the treatment of depression or other mental health disorders and chronic pain disorders is an off-label use of this drug. Ketamine is a promising treatment for people with treatment-resistant depression and other mental health disorders in addition to chronic pain disorders. However, there is limited long-term safety and effectiveness data available for use as an antidepressant. Accordingly, there are potential and currently unknown risks to the administration of Ketamine in repeated doses, and there is insufficient evidence of the safety of Ketamine in repeated doses.

Ketamine does however provide pain relief for neuropathic disorders in the form of dissociative analgesia as evidenced by its documented clinical pharmacology.

Any procedure has possible risks and discomforts. The procedure may cause all, some, or none of the risks or side effects listed. Rare, unknown, or unforeseeable risks may also occur.

Common side effects, greater than 1% and less than 10% include:

Hallucinations, nausea and vomiting, increased saliva production, dizziness, blurred vision, increased heart rate and blood pressure during the infusion, out of body experience during the infusion, change in motor skills.

These symptoms are usually mild and often dissipate within hours after the infusion is stopped.

Uncommon side effects, greater than 0.1% and less than 1% include:

Rash, double vision, pain and redness in the injection site, increased pressure in the eye, jerky arm movements resembling a seizure.

Rare side effects, greater than 0.01% and less than 0.1% include:

Allergic reaction, irregular or slow heart rate, arrhythmia, low blood pressure, cystitis of the bladder (bladder inflammation, ulcers, and fibrosis).

Other Risks:

Ketamine can cause various symptoms including but not limited to flashbacks, hallucinations, feelings of unhappiness, restlessness, anxiety, insomnia and disorientation. Individuals with a history of drug misuse or dependence can develop a dependency on ketamine. The amount of ketamine used in treatment of depression is much lower than the amount used for surgical sedation, but there is limited information about long-term safety and effectiveness and risk for addiction for repeated doses of ketamine.

With administration of any medication, including IV Ketamine, there is a risk of dosing error or unknown drug interactions which may require medical intervention including but not limited to intubation (placement of a breathing tube) and/or hospitalization. These risks can be serious and possibly fatal. To reduce these risks, it is very important that you disclose all medications, supplements, and/or other drugs that you are taking.

To administer the Ketamine, an IV will need to be inserted into your extremity. The risk of venipuncture may include temporary discomfort from the needle stick, bruising, bleeding, nerve damage, pain, infection and fainting.

Ketamine may not alleviate your symptoms. Ketamine may only temporarily relieve symptoms and may require additional future infusions.

Pregnancy

Receiving Ketamine or other drugs during pregnancy may be harmful to a developing fetus. It is the policy of Elev8 MD Wellness Center that women who are pregnant or breastfeeding or women who may be pregnant should not undergo IV Ketamine Infusion. If you are pregnant or breastfeeding, or if there is any chance that you may be pregnant, you should inform clinical staff immediately, before treatment. Elev8 MD Wellness Center offers women the option to undergo a pregnancy test in our office prior to your infusion. Should you decline, a waiver will be provided.

C. Benefits

For Chronic Pain:

Ketamine has been associated with a decrease in chronic pain symptoms with patients reporting varying lengths and levels of pain-relief. It is difficult to predict how any single person will respond to ketamine infusion therapy. Your response to treatment will be monitored by your physician and additional treatment recommendations may be made based on your response to IV Ketamine treatment.

For Depression and Other Mental Health Disorders:

Ketamine has been associated with a decrease in depression symptoms with patients reporting varying lengths and levels of relief. It is difficult to predict how any single person will respond to ketamine infusion therapy. Your response to treatment will be monitored by your physician and additional treatment recommendations may be made based on your response to IV Ketamine treatment.

D. Risk Management

Report any severe or unusual symptoms or side effects at once to the medical staff. Ask the

treatment staff if you have any questions regarding the following:

- Your medication
- Your reaction to medication
- Any possible related injury
- Your participation in the clinical treatment

On the day of the infusion, you should **NOT** engage in any of the following after the infusion:

- Driving a vehicle of any kind
- Drinking alcohol or using drugs
- Conducting business
- Participating in activities which require you to rely on motor skills or memory.
- Signing any legally binding documents

E. Voluntary Nature of the Treatment

Undergoing IV Ketamine infusion is entirely voluntary. You are free to choose to receive or not receive the ketamine infusion. Please tell the physician if you do not wish to receive the infusion.

F. Withdrawal of Treatment

Your physician has the right to stop the infusion at any time. He or she may stop the infusion with or without your consent if he or she determines it is necessary to do so in his or her medical judgment.

G. Patient Consent

A physician has discussed with me the above procedure or treatment, the anticipated benefits, likelihood of success, material risks, and side effects. Alternatives and their risks, benefits and side effects have also been discussed as well as declining the above treatment and alternative therapies.

I understand that no guarantees have been made to me regarding the results of this treatment and that it may or may not improve my condition, and that there is unknown safety or long-term effects of Ketamine administration. I have had sufficient opportunity to discuss my condition and treatment with my physicians and all of my questions have been answered to my satisfaction. I believe I have been given sufficient information and adequate knowledge upon which to make an informed decision about undergoing the proposed treatment. I have read and fully understand this form and I voluntarily authorize and consent to this treatment.

I understand that other problems/conditions may develop during the course of treatment that cannot be reasonably foreseen. I authorize Elev8 MD Wellness Center physicians to perform such unforeseen procedures or treatments necessary according to his or her medical judgment.

I understand and agree that my consent to treatment is ongoing and includes any and all repeated infusions with Elev8 MD Wellness Center.

Patient/Legal Representative_______________________________________ Date____________

Print Patient or Legal Representative ____

Physician Signature _____________________________________Date_______________

Print Physician Name____

WAIVER OF LIABILITY

On the day of the infusion, you should **NOT** engage in any of the following after the infusion:

- Driving any vehicle
- Drinking alcohol or using drugs
- Conducting business
- Participating in activities which require you to rely on motor skills or memory.
- Signing legal documents

By agreeing to this treatment and by your signature on this form, you recognize and understand the risks involved and agree to strictly adhere to these policies after every administration of the medication.

In the event you decide to engage in the above-listed activities, you agree you do so at your own peril. In no event will Elev8MD Wellness Center, its staff, physicians, employees, or agents (collectively "the Practice") be liable in any way for any personal injury, death, property loss or damage sustained by or through you in connection with my engagement after infusion in the above-listed activities. By your signature below, you agree to waive, release, and discharge the Practice from any and all liability, claims, demands, actions, and causes of actions whatsoever for any and all loss, claim, damage, injury, illness, fees or harm arising out of your participation after infusion in the above-listed activities.

This waiver will remain binding and in effect so long as you participate in treatment with Elev8MD Wellness Center.

Patient Signature:

____Date________________

Print Patient Name: ____

CONSENT TO EMAIL AND ELECTRONIC COMMUNICATION

It may become useful during the course of treatment to communicate by email, text, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Elev8 MD Wellness Center and its staff, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages;
- Your employer, if you use your work email to communicate with us;
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

If you are concerned about methods of communication that are more secured, please talk with Elev8 MD Wellness Center staff about ways to keep your communications safe and confidential. If you are willing to communicate electronically, with the understanding that it is unsecured and that your information may be accessed or intercepted by others, please proceed with signing the consent below.

CONSENT FOR TRANSMISSION OF PROTECTED INFORMATION BY NON-SECURE MEANS

I consent to allow Elev8 MD Wellness Center and its staff to use unsecured email, text, or other means of unsecured electronic communication to transmit to me the following protected health information:
(Initial the following)

_______ Information related to the scheduling of meetings or other appointments
_______ Information related to billing and payment
_______ Completed forms, including forms that may contain sensitive, confidential information
_______ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
_______ My health record, in part or in whole, or summaries of material from my health record
_______ Other information. Describe: ____

I understand that the information to be released may include the following: diagnoses and/or treatment for alcohol, drug or substance abuse; psychological or psychiatric conditions; AIDS/AIDS Related Complex (ARC) diagnoses and treatment; HIV test results; cancer diagnoses or sickle cell anemia. I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I also understand that I may terminate this consent by providing written notice at any time, but that this authorization will terminate no later than when my treatment relationship with Elev8 MD Wellness Center, PLLC. has ended.

Please clearly write the e-mail address(es) authorized for use in communications:

____

Please clearly write the cell phone number authorized for use in text communications:

CONSENT TO VIDEO MONITORING FOR PATIENT SAFETY PURPOSES

Each Ketamine Treatment room is equipped with a video device so that the patient's vital signs and medical safety can be viewed. A physician is always present in the facility and will be in and out of the treatment room multiple times during a single infusion. The video device is to detect any unforeseen issues that may arise during the rare instance that a physician is not physically present in a particular treatment room. The device **DOES NOT** have any recording capabilities. This is present to ensure each patient's medical safety every second that they are present in the facility.

_________________________________ ____________________
Signature Date

________________________________ _________________________
Printed name Relationship to patient

Privacy Policy – Elev8 MD Wellness Center

Protecting your private information is our priority.

This Statement of Privacy applies to (patient name) ______________________________and governs your data collection and usage.
By using the Elev8 MD Wellness Center website, you consent to the data practices described in this statement.

Collection of your Personal Information

We do not collect any personal information about you unless you voluntarily provide it to us. You may be required to provide certain personal information to us if you elect to use certain services available on the Site. These may include: (a) registering for an account on our Site; (b) electronic communication with Elev8 MD Wellness Center and its staff through the Site; (c) submitting your credit card or other payment information when ordering and purchasing products and services on our Site; (d) submission of information, requests, and communication through the Patient Portal.

Information collected includes but is not limited to age, gender, medical provider, emergency contact, and credit card information.

Sharing Information with Third Parties
Elev8MD does not sell or rent customer information to third parties.

Elev8MD may share your personal information, without notice, with trusted partners to collect payment, for the purposes of carrying out treatment, for administrative functions and health care operations, and to provide customer support.

Elev8MD may disclose your personal information, without notice, if required to do so by law or in the good faith belief that such action is necessary to: (a) conform to the edicts of the law or comply with legal process served on Elev8 MD Wellness Center or the site; (b) protect and defend the rights or property of Elev8MD Wellness Center; and/or (c) act under exigent circumstances to protect the personal safety of users of Elev8 MD Wellness Center, or the public.

Links
This website contains links to other sites. Please be aware that we are not responsible for the content or privacy practices of such other sites. We encourage our users to be aware when they leave our site and to read the privacy statements of any other site that collects personally identifiable information.

Security of your Personal Information
Elev8MD secures your personal information from unauthorized access, use, or disclosure. Elev8MD uses the following methods for this purpose:

SSL Protocol

When personal information (such as a credit card number) is transmitted to other websites, it is protected through the use of encryption, such as the Secure Sockets Layer (SSL) protocol.

We strive to take appropriate security measures to protect against unauthorized access to or alteration of your personal information. Unfortunately, no data transmission over the Internet or any wireless network can be guaranteed to be 100% secure. There is a chance that information you enter or share through the Elev8 MD Wellness Center website may be intercepted by third parties. As a result, while we strive to protect your personal information, you acknowledge that: (a) there are security and privacy limitations inherent to the Internet which are beyond our control; and (b) security, integrity, and privacy of any and all information and data exchanged between you and us through this Site cannot be guaranteed.

E-mail Communications
From time to time, Elev8 MD Wellness Center may contact you via email for the purpose of providing announcements, promotional offers, alerts, confirmations, surveys, and/or other general communication.

Changes to this Statement
Elev8 MD Wellness Center reserves the right to change this Privacy Policy from time to time. We will notify you about significant changes in the way we treat personal information by sending a notice to the primary email address specified in your account, by placing a prominent notice on our site, and/or by updating any privacy information on this page. Your continued use of the Site and/or Services available through this Site after such modifications will constitute your: (a) acknowledgment of the modified Privacy Policy; and (b) agreement to abide and be bound by that Policy.

Contact Information
Elev8 MD Wellness Center welcomes your questions or comments regarding this Statement of Privacy. If you believe that Elev8 MD Wellness Center has not adhered to this Statement, please contact us.

______________________________ ____________________

Signature Date

ACKNOWLEDGEMENT OF PAYMENT AND CANCELLATION POLICY

I. Payment

By my signature below, I understand, acknowledge, and agree that I am fully responsible for payment of services provided to me by Elev8 MD Wellness Center and that payment must be made in full by cash, check, HSA/FSA card or credit card at or before the time of service. Returned checks will be subject to a $50 nonsufficient funds fee.

I understand that treatment and services provided by Elev8 MD Wellness Center may not be covered by my insurance. Elev8 MD Wellness Center does not contract with any insurance plan. Elev8 MD Wellness Center can provide information to me to assist me in my claim for reimbursement to my insurance carrier but will not submit claims to insurers on my behalf.

If I have Medicare or Medicaid, I agree to disclose that information to Elev8 MD Wellness Center. In that event, I agree to complete the Advance Beneficiary Notice of Non-coverage form provided to me.

I further acknowledge and agree that if I choose to submit any bill or itemized receipt to an insurance carrier for reimbursement for these services, that Elev8 MD Wellness Center is exempt from any dispute regarding reimbursement. I fully acknowledge and agree that Elev8 MD Wellness Center is exempt from ALL claim issues regarding Medicare and Medicaid.

II. Cancellation

To fairly and effectively serve patients who wish to receive treatment, the following cancellation policy has been implemented. By your signature below you acknowledge and agree to the following cancellation policy:

Infusions must be cancelled at least 72 hours in advance. One hour infusions cancelled at least 72 hours in advance will receive a full refund. One-hour infusions cancelled less than 72 hours in advance will incur a full $425 charge, payable by funds pre-paid to your account. Four-hour infusions cancelled less than 72 hours in advance will incur a $425 charge.

Patient or Legal Representative Signature ____

Print Patient or Legal Representative Name : ____________________________________

Date________________

Patients’ Rights and Responsibilities

Some are simply based on respect. Others are based on our responsibilities as human beings. Others have evolved as the need warrants.

Consider These Patients' Rights

- The Right to Be Treated with Respect
- The Right to Make a Treatment Choice
- The Right to Refuse Treatment
- The Right to Obtain Your Medical Records
- The Right to Privacy of Your Medical Records
- The Right to Informed Consent
- The Right to Make Decisions About End-of-Life Care

The entitlement of patients' rights for Americans is accompanied by patients' responsibilities as well. In order to get the best care, and find our most successful medical outcomes, we must adhere to these responsibilities.

Consider These Patients' Responsibilities

- Maintaining Healthy Habits
- Being Respectful to Providers
- Being Honest with Providers
- Complying with Treatment Plans
- Preparing for Emergencies
- Making Decisions Responsibly
- Understanding Prescription Drugs and Their Possible Effects
- Meeting Financial Obligations
- Reporting Fraud and Wrongdoing
- Avoiding Putting Others at Risk

Late Arrival Policy

Our doctors, and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than **20 minutes late** for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate latecomers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

The doctors and staff at Elev8 MD Wellness Center truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.