Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

PATIENT _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Responsible Party's SSN _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

Please indicate with an * which phone numbers we CAN leave a message.

Patients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____

Name Phone # Relationship

How did you hear about Invictus Clinic? _____

Source of referral _____ Reason for referral _____

FINANCIAL

I understand that **Invictus Clinic, LLC** does not accept insurance. Upon request, I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, 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.

_____ _____ _____

Signature of Responsible Party Printed Name Date

OVER

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, 40 min infusion appointments take just under 2 hours, 4-hour infusions are typically around 5 hours in length. At the end of each appointment you can make arrangement 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.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit prior to the start of your appointment. If you do not have a credit card, we will accept cash and check. Please make checks payable to "**Invictus Clinic**."

5. 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 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 Invictus Clinic, LLC are ultimately your responsibility. If your insurance company requires that outpatient ketamine infusion services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper." Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

6. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at Invictus Clinic, LLC 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 Invictus Clinic, LLC and my primary care or mental health provider.

Patient Name:_____

Physician's Name/Office and Phone Number _____

Signed: _____ Date: _____

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CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS