Reverie Mind™

Patient Welcome Packet

4450 W Chandler Blvd, Suite 5
Chandler, AZ 85284

(480) 590-0092

www.Reveriemind.com

Reverie Mind™

Reverie Mind, LLC (REVERIE) would like to take this opportunity to welcome you as a new or returning patient to our facility. Infusion therapy treatments offer the welcome possibility of relief from your symptoms. However, we recognize that choosing to move forward with these treatments can be challenging and require a significant commitment. We look forward to working with you as partners in your care.

Enclosed you will find your paperwork to fill out, which is necessary to ensure you meet admission criteria for treatment. Consent forms are enclosed to help you understand the treatment, however they will be reviewed again in person. Not all patients referred to REVERIE are candidates for Ketamine therapy. Please contact us at any time with questions, comments, or for more information.

patients@reveriemind.com

www.Reveriemind.com

phone: (480) 590-0092

Submitting the forms:

Mail: Reverie Mind, LLC
4055 W Chandler Blvd Suite 5
Chandler, AZ 85226

Fax: (480) 462-5757

Or email: Upon completing the "Electronic Communications Authorization," which is part of the New Patient Registration Packet, you may email the completed forms and you may communicate with us by email regarding health information. Until you have completed the "Electronic Communications Authorization" you should not communicate confidential or health information by email.

patients@reveriemind.com

Scheduling your treatment:

After completing and submitting your forms we will schedule your treatments with you. Please make sure to bring a photo identification to each visit.

FAQ (Frequently Asked Question):

Q: Who do I call if I have to reschedule my initial treatment?

A: Please call (480) 590-0092. If you are unable to reach someone, please leave a message. Messages are checked throughout the day. ALL PHONE CALLS WILL BE RETURNED WITHIN 1 BUSINESS DAY. You may also email patients@Reveriemind.com and someone will email or call in response to your scheduling matter.

Scheduling: (480) 590-0092 or Email patients@Reveriemind.com

Behavioral Health Crisis Line: (602) 222-9444 or call 911

Emergency: Reverie does not provide Emergency Services. If you are in crisis or are having an emergency, please visit the closest emergency room or call 911.

Reverie Mind™

The following are policies of Reverie Mind, LLC Please review them carefully.

Ketamine Treatment

- Ketamine is highly effective and has shown to help about 70-80% of patients. There is no way to know who will respond, however our patients who do respond have seen dramatic improvement to their quality of life.
- Initial 6 Ketamine Infusions:
  - Initial treatment: **4 infusions** within a 2 week period, 24-48 hours apart – for example, Mon/Wed/Fri/Mon or Tues/Thurs/Tues/Thurs are typical schedules.
  - If you prove to be a good responder to Ketamine treatment, we recommend you continue with 2 additional infusions having your **5th and 6th infusions** 4 weeks apart.
- Maintenance infusions:
  - Following the initial 6 infusions, **maintenance infusions** are available for you **every 4 to 12 weeks**, depending on your response.
  - In our experience, and with patients we have treated, there is a wide range of maintenance efficacy, with anywhere from 2 weeks to 12 weeks of effectiveness. There is no way to predict how long the effect will last.
  - Another variable, is the concurrent treatment with antidepressants, in some patients, Ketamine may help relieve the acute symptoms of depression during the time it takes for antidepressants to show efficacy (6-8 weeks).
- The protocols used at REVERIE have been developed based on our review of current consensus on the off label use of this medication for the treatment of depression and other neuropsychiatric conditions.

Payment

- Initial package of 4 infusions is $1,500.
- Additional infusions and maintenance infusions are $395 each.
- Telehealth consultation outside of initial package, by Medical Director (or his designee), is $200. Please see Telehealth consent below.
- The fee is due at or before the scheduled treatment. If the complete payment is not rendered at the time of service, no service will be provided.
- REVERIE accepts Cash, Money Order, Certified Checks, Visa, MasterCard, Discover, or AMEX.
- No Refund Policy: Any payment for services already rendered or packages purchased.

Insurance

- REVERIE is not contracted with insurance companies, and does not file claims for services.
- If you wish to pursue reimbursement from your insurers, REVERIE will provide receipts for service that may be used for pursuing reimbursement.

Prescriptions

- Reverie provides **NO prescriptions**.

Communications for Regular and Urgent Matters

- If you have a life threatening emergency you should call 911. For other urgent matters, you are encouraged to direct inquiries to your referring provider, primary care, or specialty physician.
- If you have an urgent matter that is related specifically to your IV infusion treatment received from Reverie Mind, LLC, you may call (480) 626-2727.

Termination

- In some cases it may be necessary to terminate any physician-patient relationship and forgo further treatment by REVERIE for a patient. Termination may occur at any time and may be initiated by either the physician or the patient. Reasons for termination by the physician may include non-compliance with treatment, disruption of facility operations, verbal or physical abuse of facility staff, self-driving less than 12 hours after ketamine infusion, operation of dangerous machinery less than 12 hours after ketamine infusion, or other factors. Reverie Mind, LLC will continue to provide care for 30 days after notice of termination, when appropriate, in order for the patient to arrange treatment with a new provide

Reverie Mind™

Consents and Authorizations

Patient Name: _____ DOB _____

Authorization for Release of Information

I hereby authorize Reverie Mind, LLC (REVERIE) to obtain from any source and examine and use, or discuss and disclose and provide any information necessary regarding the patient with health care practitioners involved in the care of the patient. These communications of information may include unencrypted electronic communications. This authorization to obtain and release information is valid until revoked. The undersigned may revoke this consent in writing at any time, except with regard to information that has already been shared or disclosures that have already been made in reliance on such consent.

Electronic Communications Authorization

I hereby authorize Reverie Mind, LLC to communicate with me using electronic communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to REVERIE or that I have used to initiate contact with REVERIE. These communications may include appointment information, protected health information and confidential information. I understand that these electronic communications are not encrypted.

Acknowledgment of Review of Notice of Privacy Practices

I have received and reviewed Notice of Privacy Practices. Copy of Privacy Policy available upon request.

Treatment Authorization

I have the legal right to consent to medical and infusion treatment because I am the patient or I am the patient representative. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Reverie Mind, LLC and their designees are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, nurse practitioners, and other health care providers of REVERIE to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

Agreement to Pay

I understand that I am directly responsible for all charges incurred for medical services for the patient.

_____ _____

Signature of Patient or Patient Representative Date

Reverie Mind™

Consent to Treatment

Patient Name: _____ DOB: _____

I have the legal right to consent to medical and infusion treatment because I am the patient or I am the patient representative. I consent to the procedure(s) or treatment(s) as outlined below to be performed by the medical provider(s) of Reverie Mind, LLC, their staff, associates, assistants and designees to whom the physician(s) performing the procedure may assign responsibilities.

The proposed procedure(s) or treatment(s) is: **KETAMINE IV INFUSION**

The procedure(s) or treatment(s) has been explained to me in terms that I understand. The explanation included:

The nature and extent of the procedure to be performed.

- The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences.
- The benefits of the procedure.
- The estimated period of incapacity.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I understand that:

- The drugs used and rates of infusion and duration of infusion will vary from patient to patient depending on the appropriate treatment plan for each patient. For a 40 minute infusion there will be a recovery period in the office of approximately 30 minutes. For an infusion with a duration of up to two hours there will be a recovery period of up to approximately 1 hour.
- The use of Ketamine for the treatment of Depression and some other conditions are considered investigational by the Food and Drug Administration.
- Ketamine is considered useful for the treatment of Depression and some other conditions. Effects typically begin within several hours of treatment. It is also possible to have no positive effect from Ketamine infusions.
- Side effects of Ketamine may include dizziness, bad dreams, perceptual disturbances, confusion, elevations in blood pressure, euphoria, dizziness, increased libido and nausea. These side effects typically disappear at the end of the infusion.
- Ketamine is an anesthetic agents and the administration of these drugs is considered anesthesia.
- Complications with anesthesia can occur and include: drug reaction, the possibility of infection, bleeding or injury to blood vessels at the intravenous site. More severe complications could include depression of respiration and heart problems that could lead to serious consequences, including loss of life.

Reverie Mind™

Consent to Treatment *(Continued)*

Patient Name: _____ DOB: _____

I agree to the following:

- If applicable, I affirm that I am not pregnant or breastfeeding and that I have no intent of becoming pregnant in the near future. I fully understand the potential for risks to a developing embryo and fetus.
- I agree not to drive a car, operate machinery or make any legal decision within 12 hours after the procedure(s) or treatment(s).
- I am willing to keep myself safe during treatment and in between ketamine infusions.
- I agree to contact 911 in the event that I become suicidal or for any other life-threatening emergency following the procedure(s) or treatment(s).
- I agree to follow up with my referring physician or another licensed medical professional following the course of treatment, and at any time if my conditions worsens.
- I was given the opportunity to ask any questions I have regarding the procedure(s) or treatment(s) and I have had those questions answered to my satisfaction.
- I understand that I may consult or could have consulted with another physician about this procedure(s) or treatment(s).
- I understand that this procedure(s) or treatment(s) is completely voluntary and that I may pursue alternative treatments or no treatment at all for my condition(s).
- I understand that I have the right to refuse this procedure(s) or treatment(s) at any time prior to or during its performance.
- I authorize the physician to perform such additional procedures or treatments, including administering additional medications, which in his/her judgment are incidentally necessary or appropriate to carry out my care.
- If any unforeseen condition arises during this procedure(s) or treatment(s) which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize the physician to do whatever he/she deems advisable on my behalf.
- I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of this procedure(s).
- I acknowledge that I have read (or had read to me) and fully understand the information on this form. Furthermore, I certify that all my questions and concerns regarding the procedure(s) or treatment(s), its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize the physician to perform the above discussed procedure(s) or treatment(s).

_____ _____

Signature of Patient or Patient Representative Date

_____

Medical Provider Signature

Reverie Mind™

Pre and Post-Procedure Instructions

Patient Name: _____ DOB: _____

Pre-Procedure Instructions

- You may take your regular medicines as normal, including the morning of the infusion unless you are taking one of the following:
  - **Lamotrigine (Lamictal) – stop last dose only prior to infusion**
  - **Isocarboxazid (Marplan), Phenelzine (Nardil), Selegiline (Emsam), and Tranylcypromine (Parnate) - stop last dose only prior to infusion.**
    - **Emsam patch must be removed prior to infusion.**
  - **Any MAO inhibitors - stop last dose only prior to infusion.**
  - **Benzodiazepines -Xanax (Alprazolam), Ativan (Lorazepam), Valium (Diazepam), and Klonopin (Clonazepam) - stop last dose 12 hours prior to infusion.**
- You may wear comfortable street clothes during the treatment. You may wish to bring a blanket or comfortable sweater, and your favorite music and headphones.
- Plan to arrive 20 minutes before your scheduled treatment time.
- A pregnancy urine test will be obtained before infusion.
- Plan to recover for 45 minutes after a forty minute infusion before being released to go home.
- For infusions that last up to four hours you should plan on recovering for up to two hours before being released to go home.

Post-Procedure Instructions

- Arrange for someone to drive you home and for someone to stay with you throughout the next 24 hours.
- You should not drive a car, operate machinery or make any legal decision for the next 12 hours.
- You should not use any recreational drugs or alcohol for the next 24 hours.

I acknowledge that I have read (or had read to me) and fully understand the information on this form.

_____ _____

Signature of Patient or Patient Representative Date .

Reverie Mind™

Confidential Medical Information Form

Name:_____ **Date of Birth:**_____ **Age:**_____

Address: _____

Cell Phone: _____ **Other Phone:** _____

Email: _____ **How did you find us?** _____

Emergency Contact Name & Number: _____

Primary Care Physician: _____

Please specify Name of Personal or Professional Referral or Other: _____

Do you have any discontinued medications and dosages? Yes / No _____

Do you have any current medications and dosages? Yes / No _____

Do you have any allergies? If Yes, what? Yes / No _____

Have you had any past surgical procedures? Yes / No _____

Have you had any anesthesia problems with you or your family members? Yes / No _____

Conditions (Check all that apply):

	Self	Mother	Father	Siblings	Partner	Not Applicable
Depression						
PTSD						
Schizophrenia						
Suicidality						
Drug Abuse						
Alcohol Abuse						
Fibromyalgia						
RSD / CRPS						
Epilepsy						
Glaucoma						
High Blood Pressure						
Hepatitis						
Renal Failure						
Heart Disease						
Other:						

Reverie Mind™

Medical History (Check all that apply):

Migraines/Headaches	Stroke/TIA	Epilepsy
Concussions	Carotid Artery Disease	Heart Attack
COPD/Emphysema	Asthma	Bronchitis/Pneumonia
Coronary Artery Disease	Irregular Heart Beat/A-fib	High Cholesterol
Diabetes	Thyroid Insufficiency	GERD/Stomach Ulcer
Hernia	Kidney	Disease/Insufficiency/Failure
Blood Disorder	Arthritis	Dialysis
Fibromyalgia	Pain Syndromes	Chronic Pain

Cancer (type and treatment): _____

Any other health condition, not mentioned above:

_____

Social History:

Marriage status: _____ Children? _____

Number # of people in your household and ages: _____

Employer/Occupation: _____ Level of school: _____

List hobbies: _____

Do you exercise regularly? Yes / No How many meals do you eat per day? _____

Are you happy with your weight? Yes / No

When was the last time you drank alcohol, what type and how much? _____

Are you concerned about your alcoholic intake? Yes / No

List any non-prescription drug use: _____

List all medications currently taking:

Drug Name	Dose/Amount/Number	Prescribing Doctor

In the last year have you drank alcohol or used drugs more than you meant to? Yes / No

Have you wanted/needed to cut down on your drinking or drug use in the last year? Yes / No

In the last year have you used alcohol or non-prescription drugs to deal with feelings of frustration or stress?
Yes / No

As a result of drinking or drug use has anything happened in the last year that you wished hadn't happened?
Yes / No

Are you happy with your sex life? Yes / No

Describe any other stressors in your life:

_____

_____

I am not happy with My (Check all that apply):

Self	Partner	Health	Work
Life History	Suicide Attempt	Not Applicable	

Reverie Mind™