Ketamine Assisted Therapy

Psychiatric Solutions

THE ART AND SCIENCE OF HEALING
AND REWIRING THE BRAIN

Medication Disclosure and Agreement

It is important that you read and sign this agreement in regards to your Ketamine medication. By signing this form, you agree to follow the medication protocol that is put in place for our patients safety.

I_____, agree that once my ketamine is called into the pharmacy, that I will pick it up and bring it to the clinic for my first appointment unopened, where it will remain and used for my sessions.

____ I understand that my medication will be counted.

____I understand I am responsible for the cost of my medication.

Signature_____ Date_____

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