**MICHIGAN PROGRESSIVE HEALTH**

**REGISTRATION FORM**

Name _____ DOB _____

Preferred Pronouns [ ] He/Him/His [ ] She/Her/Hers [ ] They/Them/Theirs

Address _____

City _____ State _____ ZipCode _____

If patient is a minor: Guardian _____ Address [ ] Same as above

Guardian Cell Phone _____

Cell Phone _____ May we leave a message? [ ] Y [ ] N Text? [ ] Y [ ] N

Home Phone _____ May we leave a message? [ ] Y [ ] N

Email Address _____

Would you like to receive newsletters, monthly meeting reminders and clinic updates via e-mail?
[ ] Y [ ] N

What is your preferred method for the clinic to communicate with you? _____

Emergency Contact: Name _____ Relationship_____

Number _____

Primary Care Physician _____ Phone # _____

Psychiatrist _____ Phone # _____

Therapist _____ Phone #_____

Preferred Pharmacy _____ Phone #_____

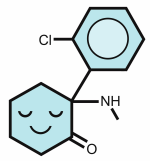
City _____ Zip Code _____

Insurance Provider Medicare? [ ] Y Medicaid? [ ] Y Self Pay? [ ] Y

Private Carrier _____

ID Number _____ Group Number _____

Who can we thank for referring you? _____




1010 N. Campbell Rd Suite 4 Royal Oak, MI 48067 248-291-7709

2300 Washtenaw Ave Suite 100 Ann Arbor, MI 48104 734-585-5587

DATE _____

## MICHIGAN PROGRESSIVE HEALTH - OFFICE POLICIES

- We at MPH hold your privacy in the utmost importance.
- We will not share your protected health information without express written permission.
- If you would like us to discuss your case with your physician, therapist or family, please have the office staff provide you a HIPAA release.
- For your safety, infusions are monitored with security cameras but are not recorded.
- Payment is due at the time services are rendered. We take cash, credit card or check.
- We do not bill insurance. At your request, we will provide you with a superbill that you can submit back to your insurance company for reimbursement if you have out of network benefits.
- If you have Medicare, you may not submit superbills for reimbursement and must sign a contract acknowledging your understanding of this policy.
- We are available by phone 24/7 and respect that you will only call in case of an urgent/emergent need.
- We reserve the right to reschedule or cancel your appointment if you are more than 15 minutes late.
- Any appointment cancelled with less than 24 hours notice will be charged 50% of the visit fee. Exceptions will be made for medical or family emergencies. Patients will be asked to keep a credit card on file and this will be charged for missed appointments without prior approval.
- You should continue to maintain a primary treatment relationship with your current psychiatrist or primary care physician, and follow-up with that person on an on-going basis after completion of your ketamine treatment. All medication changes should be done under their supervision.
- We will not refill prescriptions for your established chronic medications.
- MPH will gladly provide you a consult letter that discusses your treatment course here at no cost.
- MPH can provide you with a work note or fill out FMLA paperwork for your treatment days.
- We will not fill out short or long-term disability paperwork or write referrals to other physicians. This is the responsibility of either your PCP, psychiatrist or pain management physician.
- Ketamine treatment is an evolving science. We pledge to stay knowledgeable on current best practice in this field.
- It is our goal to help every patient we encounter. Unfortunately, we can not guarantee that patients will respond to ketamine therapy. We do not offer refunds based on failure to achieve a response or based on the quality of experience during infusions.

I have read the above statements and agree with the policies.

Name: _____ Signature: _____

## HIPAA AGREEMENT

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION - Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy

Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following circumstances may require us to use your health information:

1. To coordinate your care with your physical therapists, pharmacist, suppliers of medical equipment, referring/primary treating physician or in the event of an emergency.

2. To file claims with your insurance carrier for the purpose of billing and payment.

3. To comply with Worker's Compensation regulations.

4. At the request of public health oversight agencies that are authorized to collect information.

5. At the request of a law enforcement official.

6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others.

7. As legally required in the case of lawsuits or similar proceedings

Your rights regarding your health information:

1. Except as described in this notice, we will use and disclose your health information only with your written consent. You may revoke your consent to disclose at any time.

2. You can request a restriction in our use or disclosure of your health information. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Michigan Progressive Health.

4. You may ask us to amend your health information if you believe it is incomplete or incorrect, and as long as the information is kept by or for our practice. You must submit an amendment in writing to Michigan Progressive Health. You must provide us with a legitimate reason that supports your request for amendment.

5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy by asking the front desk.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to Michigan Progressive Health. You will not be penalized for filing a complaint.

I hereby acknowledge that I have been provided a Privacy Notice and understand my rights as a patient.

Signature:_____ Date: _____

# MICHIGAN PROGRESSIVE HEALTH

## INFORMED CONSENT FOR SERVICES

Welcome to Michigan Progressive Health (MPH). We are an innovative health clinic offering integrative ketamine treatment to individuals suffering from mental health and chronic pain conditions. MPH also supports individuals seeking personal growth, development and self-actualization. It is important to us that all patients feel welcomed, safe, supported and respected, and we will address any concerns that you may have.

As with all medical, psychiatric, and psychological care, there are both risks and benefits to pursuing treatment. **The use of ketamine for mental health and chronic pain conditions is an emerging evidence-based treatment and there can be no guarantees made as to the effectiveness of the treatment plan.** During the consultation, you will be provided with a list of alternatives to ketamine treatment. It is also highly recommended for all prospective patients to read through the information on our website as well as the related scientific studies that support the use of ketamine as therapy for these conditions.

This consent form covers six main topics. We encourage you to familiarize yourself with the services offered at our clinic as they are available to you and the standard of care that we offer. We recognize you may not utilize all of them:

- The medical risks, benefits and alternatives to ketamine treatment in any form - oral, intranasal, intravenous or intramuscular
- Discharge Instructions
- Individual Psychotherapy
- Ketamine Assisted Psychotherapy (KAP)
- Peer Support
- TeleHealth

## MEDICAL CONSENT FOR TREATMENT

- I understand that my insurance will not cover the costs of this treatment because it is considered experimental and an off label (not FDA approved) use of ketamine.
- I understand that the initial treatment can be bi-weekly, weekly, or monthly depending on the specific case. I have received an estimate of how many treatments I may need.
- I understand that maintaining a response may require repeated treatments over the course of time. Most patients receive treatment for one to two years.
- I understand that patients may sometimes feel worse before they feel better.
- I understand that the possible side effects during treatment with ketamine include increased heart rate, transient high blood pressure, feeling “unreal”, mild hallucinations, confusion, blurred vision or general anxiety. These are generally short lived and tolerated well.
- I understand that ketamine is a dissociative anesthetic and may reduce my ability to breathe spontaneously. I will therefore be monitored closely during treatment for my safety.
- I understand that there are no guarantees concerning my response or rate of relapse. The scientific research on ketamine for this use is still in the early stages. The current data show ketamine to be safe and quite effective.

- I understand that in rare cases ketamine treatment has resulted in a patient having a manic episode.
- I understand that ketamine is not safe for fetuses or infants. If I am a person of child-bearing age, to the best of my knowledge, I am not pregnant and I am not breastfeeding. If I do become pregnant, I will let the office know immediately.
- Long term side effects of medical ketamine infusions are not currently known. In the street abuse population, cystitis (bladder irritability) and cognitive impairment (learning and memory problems) have been described.
- I understand that best possible outcomes require engagement in psychotherapy and lifestyle changes.
- I understand that while it is low, there is a potential for addiction for ketamine, even when given in a controlled setting.
- I understand that data concerning my course of treatment and improvement as well as possible adverse reactions will be collected to contribute to possible research.
- I understand that for my safety, infusions are monitored with security cameras but are not recorded.
- I understand that in the event of a life-threatening emergency, 911 will be called and I will be transported to the nearest hospital.
- I understand that the alternative to receiving this treatment is to receive no treatment, continue with my current medicines or discuss other medications with my primary provider.
- I understand that ketamine may interfere with my decision making capabilities for up to 24 hours after administration. I will not drive a car, operate heavy machinery, watch small children or make legal decisions during this time period.

## DISCHARGE INSTRUCTIONS POST KETAMINE TREATMENT

Please be aware that even though you may feel “normal” now, ketamine may affect your thinking process for up to 24 hours. You should:

- Start with liquids and gradually work up to solid foods as tolerated.
- Stay home today and rest. We recommend you have a responsible adult available for you today and through the night after your first treatment.
- Do NOT do the following for 12 hours:
    - Drive or operate machinery - including your car
    - Cook or handle hot pans, dishes, etc.
    - Sign or enter into any legal contracts
    - Take any recreational or street drugs or alcohol for 24 hours
    - Strenuous activities. Walking, yoga, gardening, etc are ok.
- You may continue your normal medications unless instructed by Dr. Oxley.
- If you are having trouble sleeping after your treatment, you can use Benadryl, Melatonin or Atarax as a sleep aid.
- If you notice anything unusual or if you have questions- call Dr. Oxley @ 248.291.7709
    - If you do not reach us, you must leave a message.
    - If it is an emergency, dial 911 or go to the nearest emergency room.
- If you are feeling suicidal you can call your counselor or call our office. You may also try the National Suicide Prevention Lifeline at 1-800-273-8255 or go to your nearest emergency room.

## INDIVIDUAL PSYCHOTHERAPY

BENEFITS:

- Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater personal awareness and increased skills for managing stress. Therapy can also help people change self-destructive behaviors and habits and resolve painful feelings. Therapy can often help us understand ourselves better.

RISKS:

- Unpleasant memories, thoughts, or strong feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness may arise at times. You may experience discomfort from sharing personal information or trying and applying treatment strategies to your daily living routine.This is a normal part of the therapeutic process and we encourage you to discuss this with your therapist.

PATIENT'S RIGHTS

- Right to confidentiality: Within limits provided for by law, what you discuss in therapy shall be kept strictly confidential. Information regarding your therapy will not be shared with any person, agency, or organization outside of MPH without your prior written consent unless:
    - There is reasonable suspicion of abuse to a child, elderly person, or other vulnerable adult.
    - You present as a serious danger to yourself or others.
    - Your case file is court ordered by a judge.
- Your decision to participate in therapy is completely voluntary. You may cease to continue therapy at any time.
- You will never be forced to speak about something you do not want to discuss.
- If any questions or concerns about our work together arise, please bring them to our attention.

PROFESSIONAL RECORDS:

- Our therapist is required by law and standards of their profession to keep appropriate records of the services they provide. The brief records will note the reason for therapy, goals and progress for treatment, interventions utilized, topics discussed and your response to treatment. These records are a part of our Electronic Medical Record and you have the right to a copy of your file.

COMMUNICATION:

- If you choose to communicate with your therapist via their email or phone, please note our therapists work alternating days. Your therapist will respond to messages during their business hours. In case of emergency, see below.

## KETAMINE ASSISTED PSYCHOTHERAPY

Ketamine assisted psychotherapy (KAP) is a relatively new and innovative psychiatric/psychological treatment approach, involving the combination of ketamine administration in a safe and supportive setting, inner-directed and supportive psychotherapy,

and ongoing integration. The exact nature of the treatment process varies depending on the specific individual's needs and goals.

The benefits, risks, record keeping and communication in the KAP program are the same as individual psychotherapy, in addition to the medical information included above.

If you have received a prescription for oral or intranasal ketamine to be taken during psychotherapy, you have agreed that the medication is to be taken ONLY during psychotherapy sessions with either an MPH therapist or ketamine assisted psychotherapy partner program therapist. Failure to adhere to this guideline will result in dismissal from the clinic.

## PEER SUPPORT

This support program involves group meetings facilitated by a therapist. The group will provide space for peer support, development of coping skills, trauma and self-assessment psychoeducation, and will encourage maintenance of wellness. As with any intervention, peer support groups come with risks and benefits.

BENEFITS:

- Peer support groups often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater personal awareness and increased skills for managing stress.
- Peer support groups provide a network of support. People who have been through the same situations have a different perspective than those who haven't. You can get ideas and support from others who have been in your shoes without the fear of being misunderstood by someone who has not.
- Peer support also helps provide perspective**.** When you listen to other people talk about their struggles and problems, it can help you gain some perspective about your own struggles. This kind of connection can help you feel understood and can also help you see that there's hope because other people have gone through the same circumstance and survived.

RISKS:

- Uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness may come up from time to time in group. Unpleasant aspects of your life may be discussed. You will never be forced to speak about something you do not want to discuss.
- **There may be privacy violations that occur.** Your group facilitators are bound by law to maintain confidentiality, and group members are bound by honor to keep what is said in the group but there will always be a level of risk that something shared in confidence will be shared to others without the knowledge of the person involved.

PROFESSIONAL RECORDS:

- Our therapist will not keep records of the services provided. Your therapist is bound by law to maintain confidentiality, but may discuss your therapeutic progress with the medical team at MPH.

## TELEHEALTH

All of the services of MPH may be offered via telehealth given patient preference.
Exception - Patients who wish to be considered for ketamine assisted psychotherapy must have an in person office consultation.

- Doxy.me and GoToMeeting are HIPAA compliant Telehealth platforms.
- Patient should understand that telehealth based services and care may not yield the same results as face to face services.
- Patient understand that there are potential risks to this technology, including loss of connection, unauthorized access and technical difficulties.
- Patients are responsible to find a protected location, where it is safe and quiet.
- Patients will commit to not driving during telehealth sessions.
- There should be no one else present in the room during the telehealth appointment.
- Patients agree there will be no web surfing, phone calls, texts or emails.
- The session and chat will not be recorded unless expressly discussed prior to the session and with clinical goals in mind.
- In event of loss of connection, MPH staff will re-initiate the session.
- All rules regarding mandated reporting harm to self or others remain the same as in person sessions as mentioned above.

**FOR ALL PATIENTS**

ELECTRONIC COMMUNICATION:

- It is important to be aware that email, text and fax communications can be relatively easy to be intercepted in transmission or misdirected, which can compromise your privacy and confidentiality. Your name, email address, and any other information you offer electronically may be stored in our email system. Your use of email/text/fax to communicate indicates that you acknowledge and accept the possible risks associated with such communication. We will store each consent form you complete on a computer that is password protected. Please be aware that emails and text messages may be part of the official medical record.
    - **PLEASE DO NOT USE EMAIL OR TEXT MESSAGES TO COMMUNICATE EMERGENCIES.**

CANCELLATION POLICY:

- The scheduling of an appointment involves the reservation of time specifically for you. In order for treatment to be effective, it is important you commit to that time.
- Any appointment cancelled with less than 24 hours notice will be charged 50% of the visit fee. Exceptions will be made for medical or family emergencies. Patients will be asked to keep a credit card on file and this will be charged for missed appointments without prior approval.
- The appointment may be considered cancelled if a patient arrives more than 15 minutes after the scheduled appointment time.

TERMINATION OF TREATMENT:

- You have the right to end treatment at any time without any moral, legal or financial obligation other than those already accrued. And if you wish, we will provide you with referrals to other qualified professionals.
- We, too, reserve the right to terminate treatment at our discretion. Reasons for termination include, but are not limited to; untimely payment of fees, failure to comply

with treatment recommendations, conflicts of interest, failure to participate in treatment, patient needs are outside of our scope of competence or practice, or lack of adequate progress in treatment.

IN CASE OF EMERGENCY:

- In the event you are experiencing a psychiatric emergency during the course of treatment here at Michigan Progressive Health please do the following:

1. **Call our office – we are available 24/7 at 248-291-7709**
    a. The answering machine message will give you the number to call in case of emergencies.
    b. If no one picks up at the number, please be sure to leave a message.
    c. If we do not call back within thirty minutes, please move on to the next items on this list.
2. Call the suicide hotline at 1-800-273-8255
3. Call 911
4. Go to the nearest Emergency Center:

| Closest to Royal Oak clinic : | Closest to Ann Arbor clinic: |
|---|---|
| Beaumont Hospital | University of Michigan Hospital |
| 3601 W 13 Mile Rd. | 1500 E. Medical Center Dr. |
| Royal Oak, MI 48073 | Ann Arbor, MI 48109 |

By signing this agreement you agree and acknowledge that you have read and understand the MPH Informed Consent For Services in its entirety (Medical Consent, Discharge Instructions, Psychotherapy Consent, Ketamine Assisted Psychotherapy Consent, Peer Support, Telehealth, and For All Patients) and any questions or concerns you have regarding this agreement have been answered and resolved to your satisfaction.

Name _____Signature _____ Date _____

Witness_____Signature _____ Date _____

I, as the provider, attest that I have reviewed the medical risks, benefits and alternatives as well as the discharge instructions before the patients first ketamine treatment.

Name _____Signature _____Date _____

# CREDIT CARD PRE-AUTHORIZATION

## For Use By Michigan Progressive Health

I authorize Michigan Progressive Health to keep my signature on file and to charge my Credit Card for payment of my session and/or treatment in the amount established by my provider for the following purposes:

Please initial each box below:

☐ For a no-show or missed session and/or treatment without a 24 hour cancellation notice.

☐ For phone/telehealth sessions.

☐ For past due sessions and/or treatments.

- I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session.
- I understand that in the event of a missed or canceled session without sufficient notice (24 hrs prior to appointment start time) my credit card will be charged for 50% of the session and/or treatment rate. This fee may be waived in an "emergency", which is considered an event beyond your control or knowledge 24 hours ahead of time (such as car accident, hospitalization or sickness that keeps you from work) and this is at the discretion of your therapist.
- I also understand that if I want to use another payment method for my session(s) that I will make arrangements before the start of the session.
- I agree that this form is valid for the length of one year from the date signed.

Client's Name: _____

Card Holder's Name: _____

Card Holder's Address: _____

City: _____ State:_____ Zip: _____

Phone: _____ Email: _____

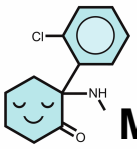
☐ Visa ☐ Master Card ☐ American Express ☐Other

Acct. # _____ CSC#_____

(3-digit # on back of card)

Cardholder Signature:_____ Exp. Date: ____/____

Patient Signature:_____Todays Date:_____




# Michigan Progressive Health

**Megan Oxley, MD**

**Royal Oak:** 1010 N. Campbell Rd., Suite 4 Royal Oak, MI 48067 **Ph:** 248.291.7709 **Fx:** 248.439.0515
**Ann Arbor:** 2300 Washtenaw Ave., Suite 100 Ann Arbor, MI 48104 **Ph:** 734.585.5587 **Fx:** 248.439.0515

## Authorization to Release / Obtain Medical Records

Patient Name:_____ Date of Birth: _____

Preferred Phone: _____

**I hereby authorize Michigan Progressive Health (Medical Providers and Therapists) to:**

☐ **Release** Protected Health Information from my medical records to: ☐ **Obtain** Protected Health Information from my medical records from:

Name:_____ Phone/Fax:_____

Address:_____ City:_____ State:_____ Zip: _____

INFORMATION TO BE RELEASED OR ACCESSED IN EITHER VERBAL OR WRITTEN FORM

Dates of Service:

☐ All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults And neuroimaging reports. This does not include any records designated as psychotherapy notes. _____

☐ Medication records only ☐ Labs and imaging studies only ☐ The following specific info only: _____

**Purpose of Disclosure:**

☐ Coordination of Care ☐ School / College ☐ Family Member Access to Treatment
☐ Consult/Second opinion ☐ FMLA / Disability ☐ Insurance application (e.g., long-term care)
☐ Transfer of Care ☐ Other: _____

1. I understand that this authorization will expire one year after I have signed this form, or as specified here:_____
2. I understand that I may revoke this authorization at any time by notifying Michigan Progressive Health or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.
   ☐ No Substance Abuse treatment should be disclosed ☐ No HIV/AIDS information should be disclosed

_____ _____
Signature of Patient Date

_____ _____
Print Name

_____ _____
Parent/Legal Guardian/Authorized Person Date

## Please send to:

**Megan Oxley, MD**
**Michigan Progressive Health**
**Fax: 248.439.0515**
**Email:**
**royaloak@michiganprogressivehealth.com**
**annarbor@michiganprogressivehealth.com**

**Patient Medication List** Name:_____

Please take the time to list your medications prior to your visit

**Current Medications:**

| Name | Dose | Frequency | Start Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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**Past Medications Trialed** (to the best of your ability):

| Name | Start Date | End Date |
|---|---|---|
| | | |
| | | |
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| | | |
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| | | |

**Allergies:**

NAME:_____ DATE:_____

# ACE Questionnaire

| **While you were growing up, during your first 18 years of life:** | YES | NO |
|---|---|---|
| 1. Did a parent or other adult in the household **often** swear at you, insult you, put you down, humiliate you, or act in a way that made you afraid that you might be physically hurt? | | |
| 2. Did a parent or other adult in the household **often** push, grab, slap, or throw something at you, or **ever** hit you so hard that you had marks or were injured? | | |
| 3. Did an adult or person at least 5 years older than you **ever** touch or fondle you, have you touch their body in a sexual way, or try to or actually have oral, anal, or vaginal sex with you? | | |
| 4. Did you **often** feel that no one in your family loved you, thought you were important or special, or your family didn't look out for each other, feel close to each other, or support each other? | | |
| 5. Did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you, or your parents were too drunk or high to take care of you or take you to the doctor if you needed it? | | |
| 6. Were your parents **ever** separated or divorced? | | |
| 7. Was a parent or stepparent **often** pushed, grabbed, slapped, or had something thrown at them, or **sometimes or often** kicked, bitten, hit with a fist, or hit with something hard, or **ever** repeatedly hit over at least a few minutes or threatened with a gun or knife? | | |
| 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? | | |
| 9. Was a household member depressed or mentally ill or did a household member attempt suicide? | | |
| 10. Did a household member go the prison? | | |