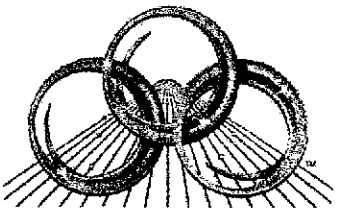
Beyond the Brain Therapies
Inc. / dba
Counseling & Mediation
Solutions LLC
651-307-4993



The Brick House
407 West Broadway Ave.
Forest Lake, MN 55025
Fax: 651-464-2289

| **Date of Intake** |
|---|

**Client's Personal Information**

| | |
|---|---|
| **Client Name** | **Birthdate** |
| **Address:** | **Preferred Phone Number** |
| **City** **State** **Zip** | **School** |
| **Email Address:** | **Place of Employment** |
| **Parent or Guardian Name (If Applicable)** | **Work Phone** |

| | |
|---|---|
| **Name of Insurance Company:**<br>**ID #**<br>**Group ID** | **Policy Holder other than client?**<br>**Birthdate of Policy Holder:** |
| **EAP or Secondary Insurance (if applicable)**<br>**ID#**<br>**Group ID** | **Provider Number to Contact Insurance?** |
| **Counselor Name:**<br>_____<br>**Services Requested: (Circle)**<br>**Counseling Biofeedback Ketamine** | **Physician:** _____<br>**Clinic:** _____<br>**Date Last Seen by MD:** |

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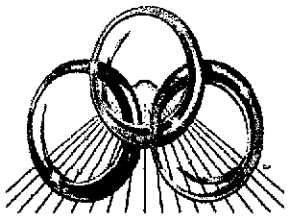

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## Acknowledgement of Electronic Communication

I understand that while every effort will be made to hold your personal information at the highest level of privacy (Federal HIPPA Standards), electronic communication is not always secure. Counseling and Mediation Solutions, LLC / Beyond the Brain Therapies Inc. has taken every step to encrypt and secure our network to meet all medical standards of compliance. Telephone, email or text exchanges will be used only for information related to treatment (including telehealth) and billing between yourself, your therapist/staff, your insurance carrier and the billing company we outsource to (Bell MedEx).

I authorize my therapist and those hired above to process my information as needed to cover my services. I have provided the following information for therapist-client exchanges:

Email _____ Email Address _____

Text _____ Cell Phone _____

**Please initial one of the following 2 options:**

_____ I authorize the release of information to my insurance or funding source. I authorize payment from my funding source for services rendered accordingly. I acknowledge and take full responsibility for amounts that are not payable by my funding source ( i.e. unbillable services, deductibles and co-pays).

_____ I opt for a private pay agreement... and that insurance will NOT be billed. An agreed upon Self – Pay in the amount of $_____ per hour has been established. I also acknowledge full responsibility for payment at time of service.

I understand that I have the option to switch insurance billing to Self-Pay or vice versa anytime. If insurance has been billed for a specific date(s) and no payment is made, I acknowledge my responsibility to pay the remaining amount.

I have read and understand the information given regarding my rights and responsibilities and the confidential commitment of my therapist (Informed Consent and Confidential Information Form).

(Client Signature)_____ _____ (Date)

(Therapist)_____ _____ (Date)

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Direct: 651- 408-3174 debranelson@beyondthebraintherapies.com Fax: 651- 464-2289

# INFORMATION FOR NEW CLIENTS (2020 Informed Consent)

**The following statements are presented to insure that you are aware of your rights and responsibilities. If you have any questions, please ask your Practitioner.**

*Please check each box to indicate that you have read and understood the information within each section:*

☐ ***What You Can Expect During Therapy***

The therapeutic process cannot be easily described because it varies depending on the health practitioner, the client, resources and the presenting circumstances.

Therapy has both benefits and risks. It can lead to a significant reduction of distress, to better relationships, and can lead to resolutions of specific issues. We cannot, however, guarantee what will happen. During the healing process, the risks may include uncomfortable feelings of sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Therapy involves a commitment of your time, money, and energy, so it is important that you are comfortable working with your practitioner and are willing to provide accurate information about yourself so you can receive the most effective treatment.

We want you to be satisfied with the quality of service you receive. If you have any questions or concerns, please talk to your practitioner immediately. If the issue remains unresolved, you may talk to owner Debra Nelson, MA LMFT at 651-307-4993. If you need to consult further, you may contact the Minnesota Board of Marriage and Family Therapy (612) 617-2220 to discuss your concerns. We are here to listen and hope you will feel safe.

☐ ***Overview of Services Provided***

We are licensed health providers who work with individuals of all ages, couples, and families on a broad range of issues such as mental health, stress, trauma, anxiety, relationships, grief, PTSD, conflict, developmental goals, career, spirituality, academics, and other issues. We work as an integrated team; each practitioner has a variety of specializations and skills.

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Counseling sessions are generally 45 to 60 minutes in length. Biofeedback is usually 90 to 120 minutes. If you would like to secure a specific weekly time of the week, please advise your practitioner. Therapy will be based on treatment goals (weekly or bi-weekly).

☐ ***Privacy and Confidentiality***

All information disclosed within sessions and any written records are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

I (the client) understand that disclosure is required by law in the following instances:

- Therapists must report known or suspected cases of incest, abuse, or neglect of children or vulnerable adults.
- Therapists must report when any client makes a specific threat of violence against another person, or if the therapist believes the client presents a clear, imminent risk of serious physical harm to self or another person.
- Parents and in some cases, legal guardians, have a right by law to information in children's files. Minors also have a right, again by law, to request that data be kept from their parents. Minnesota law requires that this request be in writing, that the child explains any reasons for withholding data from his/her parents, and show an understanding of the consequence of doing so.
- Disclosure may be required in pursuance to a legal proceeding. I understand that information, records, or testimony about me may have to be produced if there is a court order or subpoena.

I understand that each individual involved in couple, family, or group therapy must provide written authorization before the therapist can disclose any information outside the treatment context. Within couple, family or group therapy, the therapist cannot share individual confidences with the rest of the members of the therapeutic unit without written permission from the individual. Your therapist will ask for your signature on releases of information for interoffice teaming when you both agree that it is appropriate.

☐ ***Client Records***

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Private pay or cash payments will be negotiated utilizing a sliding fee & Private Pay Agreement. Other payment methods include HSA accounts, Credit Cards, Debit Cards, Cash, Check and PayPal on our website. You go online to our website www.beyondthebraintherapies.com or submit a payment at the time of service directly to your health professional.

**Appointments:** We strongly request that you give a notice of 48 hours – 2 business days when changing appointment times. We understand that a waiver for an emergency may be needed and that can be negotiated with your Practitioner. Any cancellation for services without this notice will result in a fee: $75 for first one-hour session or $150 for 1.5 hour missed session. A $100 fee will be applied for each subsequent one-hour sessions missed or $150 for 1.5-hour sessions missed. We are diligently respectful of time and hope you will be also. With that said, we do our best but there are times when sessions run over the expected end time. We do ask for your patience and understanding.

***If at any time you have an emergency, you should call 911 or 24 hour crisis 866-379-6363 as we do not have emergency staffing.**

☐ ***Relationships***

It is unethical for health practitioners to have casual, sexual, social or financial relationships with a client or his/her family member outside of therapy. A copy of the "Bill of Rights of Clients" is visible in the lobby. Therefore, no outside time-outside of therapy is allowed.

***Consent to Treatment***

☐ I knowingly give my consent to therapy and/ or biofeedback/neurofeedback services.

☐ My signature below indicates that I understand and agree with the above statements in each section of this document. I also understand that the therapeutic process isn't guaranteed, and my health professional is here to educate me on possibilities.

☐ I have received a copy of "The Health Information Privacy" document and have had an opportunity to discuss any questions or concerns I have about how PHI is being managed.

X _____ _____

***Signature of Client*** ***Date***

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| **Adult Intake Information** | **Date of Intake:** |
|---|---|

Name:_____ Birthdate: _____

Gender Status: _____ (Optional) Pronoun Preference: _____(Optional)

**Marital Status**: (circle all that apply)

Single Married Separated Divorced Widowed Engaged

Date: _____ _____ _____ _____ _____

Services Desired: Circle all that apply Counseling Biofeedback Ketamine Other

_____

How long have you experienced the concern(s)?_____

Military History: YES NO Branch: _____

Spiritual Affiliation? YES NO _____

Sports / Hobbies _____

Who Resides with you?_____

Are you satisfied with your relationships? YES NO Concerns of Abuse? YES NO

Have you attempted to resolve the concerns previously? Describe your attempts:

_____

_____

What do you like about your life? _____

What would make your life better? _____

Primary Physician Info: _____

MENTAL HEALTH AND MEDICAL INFORMATION:

Past Diagnosis for Mental Health _____

_____

Past Diagnosis for Medical Health: _____

_____

Medications Currently Taking: _____

_____

Food/Medication Allergies: _____

**What physical or mental health issues are your experiencing lately?**

| Symptom | Check if yes | Symptom | Check if yes |
|---|---|---|---|
| Sleeplessness | | Too much sleep | |
| Anxiousness | | Depression | |
| Grief | | Eating Problems | |
| Confusion | | Perfectionism | |
| Concentration | | Dependency | |
| Loneliness | | Self Harm | |
| Guilt | | Suicidal Thinking | |
| Unassertive | | Suicidal Attempts | |
| Self Esteem | | Chemical Dependency | |
| Legal Issues | | Memory Issues | |
| Isolation | | Unable to Work | |
| Stress | | Physical Complaints | |
| Lying | | Manipulation | |
| Anger | | Panic Attacks | |
| Employment Issues | | Addiction Issues | |
| Relationship Issues | | Parenting Issues | |
| Obsessive Compulsive Thinking | | Hair Pulling | |
| Sexual Problems | | Identity Issues | |
| Sexual Abuse | | Physical Abuse | |
| Emotional Abuse | | Trauma | |
| Lack of Motivation | | Stress | |
| Lack of Employment | | Unusual Thoughts | |
| Spiritual Concerns | | Loss of Support | |

1. At the present time, how upset or distress have you been feeling lately?

Not 1 2 3 4 5 6 7 8 9

2. At the present time, how healthy do you feel?

Not 1 2 3 4 5 6 7 8 9

3. At the present time, how tired have you been feeling?

Not 1 2 3 4 5 6 7 8 9

4. At the present time, how satisfied are you with your life in general?

Not 1 2 3 4 5 6 7 8 9

5. Are you concerned with your use of alcohol, drugs or prescriptions?

Not 1 2 3 4 5 6 7 8 9

6. At the present time, how satisfied are you with relationship closeness in your life?

Not 1 2 3 4 5 6 7 8 9

7. At the present time, how satisfied are you with your social life?

Not 1 2 3 4 5 6 7 8 9

8. How satisfied are you with your career?

Not 1 2 3 4 5 6 7 8 9

9. Are you able to handle self care and daily living?

Not 1 2 3 4 5 6 7 8 9

10. How often do you experience loneliness depression symptoms?

None 1 2 3 4 5 6 7 8 9

11. How often do you experience suicidal ideation (thoughts of wanting to die)?

None 1 2 3 4 5 6 7 8 9

12. How many medication have tried for the treatment of depression anxiety ptsd (circle)?

None 1 2 3 4 5 6 7 8 9

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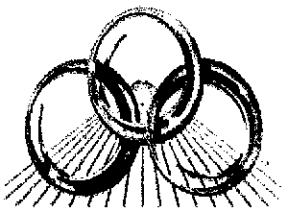

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**"PERSONAL HEALTH INFORMATION"**

The privacy of your health information is important to you and to me. Additionally, as a Licensed Marriage and Family Therapist, I am required by law to secure your "protected health information" (PHI). This information includes:

1. I must protect PHI that we have created or received about your past, present or future health condition, health care we provide to you or payments we receive;
2. I must notify you about how we protect PHI about you;
3. I must offer you explanation of how, when and why we use this information;
4. I may only use and/or disclose PHI if we have discussed it and you have agreed; and
5. I will and must abide by the terms of this notice.
6.

## Minnesota Patient Consent for Disclosures

For most disclosures of your health information we are required by the State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care services or at a later point in your care, when the need arises to disclose your health information to others.

**Uses and Disclosures**

A. For the purposes of treatment, payment and health care operations:
   1. Health Care Treatment: We may use and disclose PHI to provide, coordinate and/or manage your health care and related services. This may include communication with other health care providers regarding your treatment and coordinating and managing the delivery of health service with others.
   2. Payments: I may use and disclose your medical information to others to bill and collect payment for treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill ay include

information that identifies you, as well as your diagnosis. Before you receive scheduled services, we may share information about these services with your health plan to achieve authorization. Sharing information allows me to ask for coverage under your plan or policy and gain approval of payment before we meet. I may also share portions of your medical information with the following:

a. The billing service I utilize (Greater Lakes Medical Billing);
b. Collection agency;
c. Insurance companies, health plans and agents;
d. Personnel that review the care you receive and the costs associated; and
e. Consumer reporting agencies.

B. Requiring your Authorization: You may give us written authorization, different from the Minnesota Patient Consent, to use your health information for disclosure. If you give me an authorization, you may revoke it in writing at any time. Unless you give a written authorization, I cannot use or disclose your health information for any reason except those described in this notice.

C. Require your Opportunity to Agree or Object: I will provide you the opportunity to agree or object to a use or disclosure of your PHI in the following instances:

1. If I need to disclose information to notify a family member, personal representative, or another person responsible for your care, your location and general condition

2. Communication with family members: health professionals, using their best judgment may disclose to a family member, other relative, close personal friend or any other person who you identify, health information relevant to that person's involvement in your care or payment related to your care.

You have the right to object to my use or disclosure of PHI in the either of the above situations. I will take your wishes very seriously and do all I can under the law to work in your best interest.

D. Circumstances in which I am authorized by Law to release personal information that DO NOT require your Consent, Authorization or Opportunity to Agree or Object are:

1. When the use and/or disclosure is authorized or required by law;
2. When the use and/or disclosure is necessary for public health activities;[1]
3. When the use and/or disclosure relates to victims of abuse or neglect;
4. When the use and/or disclosure is for health oversight activities;
5. When the use and/or disclosure is for law enforcement purposes;

6. When the use is for disclosure related to decedents;
7. When the use is to avert a serious threat to health and safety;
8. When the use disclosure related to specialized government functions; and
9. When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.

## Know Your RIGHTS!

A. You have the right to request restrictions on uses and disclosures of personal health information. I am not required, however, to agree to your request but at all times I am committed to work with you as long as it is within the ethical and legal parameters set by the State of Minnesota and the Minnesota Board of Marriage and Family Therapy.

*For example, emergency care treatment; you may request a restriction be given related to the release of information to the Secretary of the Department of Health and Human Services by submitting it in writing to me. You will then be notified as to whether your request can be honored.*

A. You have the right to request communications via alternative means or to alternative locations.
B. You have the right to see and retain a copy of the Personal Health Information outlined.
C. You have the right to see and receive a copy of your clinical, billing and other records used to make decisions about you. Your request must be in writing. You may incur a charge for this service. There are certain situations which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of the denial.
D. You have the right to request an amendment to your personal health information.
E. You have the right to request an accounting of disclosures of personal health information.
F. You have the right to receive a copy of this notice.

This document has been created from legal guidelines and is intended for the purpose of educating you of your rights and my professional obligations. If at any time you have concerns or questions, please discuss them with me and/or submit your complaint in writing. This herein, serves to meet the State and Federal procedures for "Personal Information Disclosure".

Thank you!

## *Beyond The Brain Therapies Inc.* *Tips to Natigate Ketamine Therapy Services...*

| First Step /Session | Second Step / Session | Third Step/Session | Fourth Step/Session |
|---|---|---|---|
| **Schedule a Mental Health Intake with OUR Practitioner**<br><br>Bring Documentation of your mental health and medical history (including diagnosis)<br><br>Bring provider information so we can send a request to collaborate and get clearance for the procedure. This is done because there are medication and diagnostic disqualifiers to be considered | **Schedule Second Intake Session-Finish Mental Health and Medical History**<br><br>Medical Intake – Evaluation Send Collaboration Referral to Primary Physician to Approve Services. Please discuss administration of zophran for nausea as well. | **Mental Health Preparation for Ketamine Services**<br><br>Video preparation for Ketamine Session will include Question & Answer Session, Setting the Stage, Increasing Knowledge and Determine Intention.<br><br>Bring Signed Collaboration Referral or Request from MD | **Schedule Ketamine Session**<br><br>60 to 90 Minute Session will be administered by an MD and/or RN. Average is 5-6 sessions.<br><br>Sessions may include anti-nausea medication unless otherwise specified by you Primary Care Doctor.<br><br>*See Preparation Sheet for details on preparing for sessions |
| **Payment Planning:** | **Payment Planning:** | **Payment Planning:** | **Payment Planning:** |
| Insurance usually covers MH Intakes (Billing Code 90791) *Depending on your insurance coverage, you may owe a co-pay or deductible. This is generally the same amount as a doctor visit.<br><br>Private Pay $250 | Insurance usually covers Individual Sessions (Code: 90837). Again, you may owe a copay or deductible, depending on your insurance plan.<br><br>Private Pay $200 | Insurance usually covers Individual Sessions (90837 / 99201/ 99211). Again, you may owe a co-pay or deductible, depending on your insurance plan.<br><br>Private Pay $200 | Ketamine medicine services are covered by some insurance companies. Please consult your company's customer service to verify eligibility for session(s) (96365/96366/90839 J3490) - Please advise us.<br><br>Private Pay $450 |

* We do accept payments through HSA/Credit Card/Cash/Paypal/Venmo/Cash App. *Payments are required at the time of service.

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# Informed Consent for Ketamine Therapy (IM)

The label information on the container, in the package insert, in the Physician's Desk Reference (PDR) and in the advertising can indicate a drug's use only in certain "approved" doses and routes of administration of a particular condition. The use of a drug for a disease not listed on the label, or in a dose, or by a route not listed on the label is conserved to be an "off-label" use of the drug. Medical care providers based on their knowledge and on available current information, may use a drug for a use not indicated in the approved" labeling if it seems reasonable or current information, seems reasonable or appropriate.

- I know that ketamine is NOT an FDA approved treatment for pain, depression, bipolar disorders or PTSD.
- I know that my taking part in this procedure is my choice
- I understand that the dose given will be injected and is lower than other medical procedures
- I know that I may decide NOT to take part or to withdraw from the procedure at any time
- I also know that the staff may stop the therapy without my consent
- I also know that ketamine therapy may NOT help my condition
- I have had a chance to ask questions about this treatment and was referred back to my Primary Physician prior to starting any medicine.
- I am satisfied with the information and answers I have been provided.
- The nature and possible risks of ketamine infusions have been fully explained to me.
- The possible alternative methods of treatment, the risks involved, the possibility of complications have been fully explained to me.
- I understand that there are no guarantees or assurances for the outcome of this therapy.
- I release the above company and their consultants from all liabilities and outcome results.

## SIDE EFFECTS WHICH MAY OCCUR

Nausea, vomiting, hallucinations, increased saliva production, dizziness, blurred visions, increased heart rate and blood pressure during sessions, impaired motor skills, and out of body experiences. The staff will monitor your vitals. **If you wish for staff to stay in the room, we will do so for the first 15 minutes.**

## Uncommon Side Effects

Rash, double vision, pain or redness at the injection site, increased pressure in the ye, jerking arm movements, allergic reaction, irregular or slow heart rate, arrhythmia, low blood pressure, cystitis of the bladder, constipation

## Other Potential Experiences

- Ketamine may cause various symptoms including but not limited to flashbacks, hallucinations, feelings of unhappiness, restlessness, anxiety, insomnia and disorientation
- Allergic reaction from materials containing latex, ketamine and or other medications or medical supplies
- Infection on skins, tissue, bones, joins, nerves, ligaments, possibly blood stream and brain may require hospitalization from medical supplies and or medications
- Nausea, vomiting and gastric contents (vomitis material) can be aspirated and can cause serious lung disease such as Aspiration Pneumonia and Pneumontitis
- Changes in blood pressure, eye injury, peripheral nerve injury, drug reactions, cardiac arrest, strokes, hear attack, brain damage, lesions, paralysis or death
- There is a potential risk of dosing error or unknown drug interaction that may require medical intervention including intubation (putting gin a breathing tube) or hospitalization
- The risk on venipuncture may include temporary discomfort fro the needle stick, bruising, infiltration or infection. Fainting may also occur.
- Risk of discomfort in answering questions about your mental health, drug and alcohol use.
- Lastly, ketamine may not help your condition.

## BENEFITS

Ketamine has been associated with a decrease in pain, depression, bipolar, and PTSD and other mood and substance use disorder symptoms. Results lasting for days to weeks to months. There is no way to predict the outcome of how any single person will respond to the ketamine infusion therapy. These effects may not be long lasting and will most likely require further infusions.

## RISK MANAGEMENT

- You must report any unusual symptoms or side effects at once to the medical staff or your Primary Physician. We will work diligently to collaborate with your health team.
- On the day of Ketamine services, do not drink or eat for 4 hours prior.
- On the day of Ketamine services, you should NOT have any of the following:

| | |
|---|---|
| *Driving | *Conduct Business |
| *Drinking Alcohol | *Operate Machinery/Equipment |

# KETAMINE INFORMED CONSENT SIGNATURE PAGE

You have a pain problem and/or a mood disorder that has not been relieved by routine treatments. Ketamine therapy is not indicated for further evaluation or treatment of your pain and or mood disorder. You have discussed this with your Primary Care Physician and our company has collaborated to gather the necessary information related to your care. You have been informed and received the list of benefits and risks associated with this process. You have chosen to voluntarily elect this medicine therapy to help your hard to treat condition. There are no guarantees that Ketamine therapy will cure your pain or mood disorder. In rare cases, it could become worse, even when the injection was completed in a technically perfect manner. The degree and duration of relief varies from person to person. So, after the session, we will reevaluate your progress, and then determine if further treatment is helpful. Your provider will explain the details of the procedure. Alternatives to the procedure include medications, physical therapy, psychotherapy, counseling, acupuncture, biofeedback, massage, surgery, herbs, supplements, interventional treatments, etc... The benefits include increased likelihood of correct diagnosis and/or decease or elimination of pain or mood disorder.

The incidence of serious complications listed above requiring treatment is low, but it may still occur. Your provider and other members of your care team believe the benefits of ketamine therapy outweigh its risks or it would not have been offered to you. It is your decisions and right to accept or decline to have the procedure done. I have read or had read to me the above including including the Pre=Procedure Patient Instruction page. I UNDERSTAND that there are risks uninvolved with the ketamine injection, to include rare complications, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to the Ketamine Injection Therapy. The options, risks and benefits of the ketamine therapy have been discussed with me. All of my questions have been answered to my full satisfaction. By signing this request form, I am indicating that I understand the contents of this document; I agree to its provisions and consent to the administration of ketamine medicine. I am also acknowledging that the practice of anesthesiology, medicine and pain management is not an exact science and that no one has given me any promises or guarantees about the administration of ketamine or its results. All blanks or statements requiring insertion or completion were filled in before I signed this consent and all of my questions have been answered to my satisfaction. I have been directed not to drive a car, operate machinery or make important decisions for at least 24 hours after ketamine injection therapy.

**Patient Name** _____ **Patient Signature** _____ **Date**_____

**Provider Name** _____ **Provider Signature**_____ **Date**_____

**Witness Name**_____ **Witness Signature**_____ **Date**_____

## Ketamine Pre-Treatment Checklist

* **Secure a pre-service referral** and clearance from your Primary Physician before scheduling
* **Discuss disqualifying factors** Including medications, physical and mental health diagnosis
    * Have Physician fax form to: 651-464-2289 or

      Email to Susanpearson68@beyondthebraintherapies.com
* If you experience headaches, please discuss best options with your physician prior to therapy
* Day of service, **DO continue taking medications as prescribed**. Some medications are contraindicated; discuss these details with your primary physician when you obtain a referral
* **Advise medical staff if you are prone to nausea**. Some people experience nausea for a short time during and/or after sessions. There are medications to reduce this from happening
* **Hydrate! Stop all fluids two hours before your ketamine session.**
* **Minimize eating prior to your treatment**. A light snack is okay
* **Wear comfortable clothing** to your appointment and **bring a blanket and pillow** if you like
* Start your medical portal account (Your Counselor will have sent you a link)
* It's a good idea to **bring headphones or earbuds** but there is music and video in the room
* **Driving is prohibited for 12 to 24 hours after ketamine therapy**. A consent form must be pleted by the driver prior to services and then again prior to releasing you to leave
* **Advise your medical transportation service that they will need to check in** prior to treatment

## Ketamine Post-Treatment Checklist

* Effects of the ketamine may linger for up to 24 hours after treatment
* If you experience dizziness: rest, relax and listen to your body
* **Hydrate! Avoid using alcohol or other substances**
* Do not make big decisions or operate machinery for 24 hours after ketamine therapy
* It is normal to experience some emotional shifting during the process. Be sure to pre-schedule appointments with your counselor. This will help ensure the greatest success!
* **Be sure to communicate concerns with your care team through your medical portal account**
* **If you ever feel unsafe, promptly call 911 or 24 hour hotline 988 (text or call)**
* Non emergency needs during business hours (651-307-4993)