SEQUOIA
MIND HEALTH

PATIENT CONSENT FOR NON-COVERED SERVICES

Not all services are covered by your health plan policy. All services must be medically necessary care, as defined by your health plan to be reimbursed by that plan.

Certain services are not considered medically necessary by your health plan. They may be helpful to you, but the terms of your plan do not pay for these services. These non-reimbursable services and/or supplies are typically the responsibility of the patient. Listed below are services not covered under your current health plan contract but are being recommended by your provider.

NON-COVERED SERVICE:

☐ Ketamine: IV (Intravenous) Fee: $500

☐ Ketamine: IM (intramuscular) Fee: $450

☐ Series (6) Ketamine: IV Fee: $2,700

☐ Series (6) Ketamine: IM Fee: $2,430

☐ Mixed series _____ IM, and _____ IV: total cost: $_____

I, _____, a patient of Cuyler Goodwin, D.O., acknowledge and agree that part of my care is not a covered benefit of my health plan. I acknowledge and understand that I will be financially responsible for this part of my treatment. I also acknowledge and understand the information listed below:

- My provider and I have discussed the reasons for requesting non-covered services and what my alternatives are; my provider has allowed me to make the final decision regarding such services.
- I have been advised the recommended services will not be covered by my health plan and I will be solely responsible for payment of the recommended services.
- By signing this document, I am agreeing to pay for these services and charges prior to such services being rendered.
- I understand this not an ongoing authorization but is specific to the treatment plan discussed with me. The treatment plan includes:

Specific non-covered service provided by Cuyler Goodwin, D.O., at 1506 4th St, Santa Rosa on:

(1 visit) _____ / _____ / _____ Initial: _____

Series of 6 Ketamine non-covered services provided by Cuyler Goodwin, D.O., at 1506 4th St, Santa Rosa on:

#1 _____ / _____ / _____ Initial: _____
#2 _____ / _____ / _____ Initial: _____
#3 _____ / _____ / _____ Initial: _____
#4 _____ / _____ / _____ Initial: _____
#5 _____ / _____ / _____ Initial: _____
#6 _____ / _____ / _____ Initial: _____

I understand the treatment plan is for a period no longer than three months. Should the treatment plan extend beyond that time frame a new authorization or a re-signing of this agreement will be required.

Patient Name	Patient Signature	Date

Physician Note: I have discussed all information listed above with my patient and provide the following reasons why services are not covered: *Ketamine is not FDA-approved for the treatment of depression.*

Cuyler Goodwin, DO, MPH

Provide copy of this document to patient