MAC Wellness Center
Ketamine Infusion Therapy
Mobile Anesthesia Care (*Division of Anesthesia Associates of KC, PC)*
8717 W 110th St. Suite 600 Overland Park, KS 66210

Schedule: (913) 428-2939
Payment: (913) 428-2934
Fax: (913) 428-2784
Email: wellness@macofkc.com
Website: www.macofkc.com

Patient Information: (Please Print)

Last Name: _____ First Name: _____ Nickname: _____

Date of Birth: _____ Gender: ❑ F ❑ M Primary Language: ❑ English ❑ Other: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact #: _____ ❑ Cell ❑ Home/Landline

Email Address: _____ Preferred Method of Communication: ❑ Text ❑ Email ❑ Phone

I'm seeking Ketamine therapy for: ❑ Depression ❑ Anxiety ❑ OCD ❑ PTSD ❑ Chronic Pain ❑ Addiction

How did you find us? ❑ Physician Referral ❑ Family/Friend ❑ Google ❑ Facebook ❑ Website ❑ Other _____

Acknowledgement of Receipt of Notice of Privacy Practices: (place a check or "x" to signify permission)

❑ I acknowledge that I have been offered a copy or have seen the Notice of Privacy Practices located on the Practice's website.

❑ I give permission for the practice to contact me on any of my preferred methods of communication noted above.

❑ I give permission to leave a voicemail on the phone number noted above.

❑ I give permission to leave a message or speak with anyone listed below regarding my healthcare:

Name: _____ Relationship: _____ Contact #:_____
Name: _____ Relationship: _____ Contact #: _____

Acknowledgement of Financial Responsibility: (place a check or "x" within each box to signify understanding)

❑ I understand that IV ketamine therapy is considered "off-label" for treatment of mental health and chronic pain disorders and, therefore, is not typically reimbursed by insurance companies.

❑ I understand that I am responsible for pre-payment of any treatments I elect to receive.

❑ I understand that MAC Wellness will not submit a claim to my insurance for any treatments I elect to receive.

❑ I understand that I may request a receipt of any payment(s) made to MAC Wellness, so that I may submit a claim for reimbursement to my insurance provider, HRA or FSA accounts, as I desire.

Patient Signature: _____ Date: _____