The Ketamine Research Foundation

Application for <u>Access to Care</u>

Date of Application___________________

Provider Name____

Provider Address____

Provider email_____________________________

Provider Telephone_________________________

Patient Code__________ Age________ Sex: M F

Patient Diagnosis(s)—ICD 10______________ Duration________________

History of ketamine sessions (# and route) __________________________

Support for 1-3 sessions: 1 2 3

Provider's Usual Fee__________ Half Fee__________

Patient Agrees to Pay Half of the Half fee: Y N

Patient has or is eligible for Medi-Cal/Medicare: Y N

I hereby state that all the above is true to the best of my knowledge, and I/we agree to the terms of Foundation support.

Signature__________________________________

Please return application to : ketamine.research@gmail.com