SPRAVATO CONSENT AND PATIENT RESPONSIBILITIES FORM

Instructions: Please read and initial after each of the following statements.

INFORMATION ABOUT SPRAVATO

The use of SPRAVATO for treatment resistant depression has been thoroughly explained to me. I have been given the opportunity to ask questions about the treatment and my care and they have been answered. _____

My CBC clinician and I have discussed the potential risks and side effects associated with SPRAVATO and I have been provided the website address for SPRAVATO as well as printed handouts regarding those potential risks and side effects. _____

I understand that each treatment visit will last between two and three hours and I understand that it will be necessary for me to stay at Carolina Behavioral Care for monitoring for at least two hours for each SPRAVATO treatment. _____

I understand I can contact my Carolina Behavioral Care provider on call at (919) 972-7700 if I have questions or concerns after hours following my SPRAVATO.
treatment. _____

I understand I can discontinue SPRAVATO treatment at any time. _____

I understand that my SPRAVATO treatment can be discontinued at any time if my provider deems it medically appropriate. _____

I understand that I can revoke this consent at any time, including during a treatment visit. _____

PATIENT RESPONSIBILITIES

I understand that I must enroll in the SPRAVATO REMS program and receive a REMS identify-cation number before I can begin treatment. _____

I understand that I am not supposed to drive the day of treatment and agree to have a licensed driver drive me home from Carolina Behavioral Care after treatment. I will not drive until after sunrise the day after my SPRAVATO treatment. _____

I understand that the rendering provider is only managing my SPRAVATO treatment. I understand and agree that another mental health provider will continue to manage my basic mental health care and prescribe my mental health medications during SPRAVATO treatment. _____

My current mental health provider is _____.

PATIENT RESPONSIBILITIES, CONTINUED

I understand I must notify Carolina Behavioral Care if there are changes in my medical, mental, or physical health, or if my other providers change. _____

(Females only) I confirm that I am not pregnant, am not trying to become pregnant, and agree to notify my CBC provider if I should become pregnant as long as I am receiving SPRAVATO treatment. _____

I understand and agree that I am responsible for and will update CBC about any changes in my insurance in advance of my visits, and that I will provide Carolina Behavioral Care with a copy of my current insurance card and information prior to my appointment or when I check-in for each SPRAVATO treatment. _____

ACKNOWLEDGMENTS AND AGREEMENTS

I understand and agree that I am responsible for the full cost of healthcare services provided to me by Carolina Behavioral Care in the event my health insurance fails to pay or if my benefits end for any reason. _____

I hereby authorize treatment by the providers of Carolina Behavioral Care. I grant permission for any Carolina Behavioral Care staff person to seek emergency care from a hospital or physician on my behalf in the event Carolina Behavioral Care believes I am in need of emergency treatment. I will not hold this person or Carolina Behavioral Care accountable for associated expenses. _____

Any questions regarding all of the above have been answered to my satisfaction and understanding. _____

Patient Name and Signature	Date
Provider Name and Signature	Date