**ADVANCED TMS CENTER**

333 Corporate Drive, Suite 260

Ladera Ranch, CA 92694

(949) 768-2988

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**P A T I E N T**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

 Telephone Numbers: home #: (\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Okay to Leave Messages: Yes No

 work #: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Okay to Leave messages: Yes No

 cell#: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer’s name & address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single / Married / Divorced

 Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Nearest Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nearest Relative’s Address & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I N S U R A N C E**

 Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insured’s Soc. Sec. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insured’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

 Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_

 Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Is there secondary insurance?** \_\_\_\_\_\_\_\_ If so, please request a separate form for Secondary Insurance.

**AUTHORIZATION (Signature on File)**

|  |
| --- |
| I authorize use of this form on all my insurance claim submissions.I authorize the release of any medical, mental illness, substance abuse or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill, even in the event that services are not authorized by my insurance company. I agree to pay any deductibles, copayments and coinsurance as instructed by my insurance company.I authorize **Advanced TMS Center** to act as **my** agent in helping to obtain payment from my insurance carrier(s).I irrevocably authorize payment of medical benefits directly to **Advanced TMS Center** for services rendered to me.I request payment of government benefits be made directly to **Advanced TMS Center**, who hereby accepts such assignment. I permit a copy or fax of this authorization to be used in place of the original. |
|  Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Advanced TMS Center -- PATIENT CONSENT FORM**

(protected health information or “PHI”)

**Acknowledgement of Notice of Privacy Practices**

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Advanced TMS Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at **www.AdvancedTMSCenter.com** and in our office. You may request a copy of the Notice of Privacy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient /Patient Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient/ Patient Representative (please print) Relationship to Patient

**By signing below you give consent for your doctor to view any external medication history as part of the electronic prescription (eRx) process, as well as check if your insurance covers any future prescriptions.**

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

NOTICE TO CONSUMERS

Osteopathic physicians and surgeons (D.O.)are licensed and regulated

by the Osteopathic Medical Board of California.

(916)928-8390

[www.ombc.ca.gov](http://www.ombc.ca.gov)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Advanced TMS Center

## 333 Corporate Drive #260 Ph 949-768-2988

## Ladera Ranch CA 92694 Fx 949-768-2980

**NEW PATIENT HISTORY FORM. NOTE: Write “NA” or “no” if a question doesn’t apply. Note: All of this information is subject to doctor-patient confidentiality, refer to privacy policy.**

Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_ Page 1 of 3

Age:\_\_\_\_\_ Marital status (circle): SEP S M D W Number of children:\_\_\_\_\_\_\_\_\_\_\_

Name & **phone #** of primary care physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names of others you live with (+ages if minors): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation or school program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the main symptom or problem for which you are here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel sad or down most days for the past 2 weeks?\_\_\_\_\_\_\_\_\_\_. If longer, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 On a scale of 0-10, where 10 is the worst, how depressed are you most days?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it take you to get to sleep:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List sleeping pills now on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you awaken after sleep, how often & for how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is appetite higher or lower than normal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. List weight change in past 3 mos:\_\_\_\_\_\_\_\_\_ lbs.

Is energy level higher or lower than normal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lost interest in or ability to enjoy usual activites?\_\_\_\_\_\_\_\_. If so, for how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel overly negative or hopeless?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have excessive or inappropriate guilty feelings?\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with memory & concentration? \_\_\_\_\_\_\_\_\_\_. Describe them:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any problems you have doing your job now:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you overly irritable? If so, describe symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide before?\_\_\_\_. If yes, list when & what happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any family member ever attempted suicide?\_\_\_\_. If yes, list when & what happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to any guns or weapons?\_\_\_\_\_\_\_\_\_\_\_\_\_

List dates of any prior depression, manic or other psychiatric episodes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**:\_\_\_\_\_\_\_\_\_\_\_\_ New Pt. History, page 2 of 3

Did you ever have several days of feeling euphoric, racing thoughts, excessive energy, more talkative & less need for sleep?\_\_\_\_\_\_\_\_

If so, describe pattern & duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any excessive anxiety or worry you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you have physical panic attacks out of the blue, answer: How often do they occur:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all the physical symptoms in an attack:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had delusional thoughts, paranoia, or hallucinations of any kind?\_\_\_\_\_\_\_

Describe any excessive worry causing you problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any others fears or phobias:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any situations or places you avoid due to fear of anxiety:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had symptoms of an eating disorder, even if never treated for it?\_\_\_\_\_\_\_

Have you ever had obsessive thoughts or compulsive behavior causing problems or lasting > 1 hr/day?\_\_\_\_\_

Were you ever tested for or diagnosed with ADD prior to age 7?\_\_\_\_\_\_\_\_\_.

List any excessive worries about your health or getting any particular disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any snoring or irregular breathing or gasping at night?\_\_\_\_\_\_

Describe in general terms any prior trauma or abuse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications, dosages (even over the counter or supplements). List start date for psychiatric meds:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medication allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any side effects to current medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had abnormal movements of your lips, tongue, or mouth?\_\_\_\_\_\_\_ Any dentures?\_\_\_\_\_\_\_

List any complications of your birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any learning disabilities or dates of special education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the highest grade or college from which you graduated or attended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names & dates of any prior psychiatrists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names & dates of prior psychotherapists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names & dates of prior psychiatric hospitalization(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prior psych medications, dosages & dates taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prior medical problems & surgery dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any hospitalizations for medical reasons overnight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**:\_\_\_\_\_\_\_\_\_\_\_\_ New Pt. History, page 3 of 3

Females, please list total # of pregnancies:\_\_\_\_\_\_. Please list birth control method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Do you plan more pregnancies?\_\_\_\_

Have you ever had plastic surgery or strongly considered it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any psychiatric or drug or alcohol issues in extended blood family members:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you have ever had problems with any of the following: Heart & rhythm\_\_, thyroid\_\_\_, high cholesterol\_\_, diabetes\_\_\_, high blood pressure\_\_\_, liver\_\_\_, kidneys\_\_\_, seizures\_\_\_, loss of consciousness\_\_\_, glaucoma\_\_, brain infection (meningitis)\_\_, neurologic problems\_\_\_, fainting spells\_\_\_, chronic severe headaches\_\_\_.

Have you ever had a brain scan? If so where, when & who ordered it:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When were & who ordered your last blood (lab) tests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cigarettes do you smoke daily:\_\_\_\_ Total duration of smoking (years):\_\_\_\_\_\_\_.

How many caffeinated drinks daily:\_\_\_\_\_\_

Did you ever have a problem with prescription drugs, take them the wrong way or been hooked on them?\_\_\_\_

Did you ever have a problem with over-the-counter meds, take them wrong way or been hooked on them?\_\_\_\_

List any prior street drug usage & dates of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any traumatic brain injuries (TBI)? If so when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to Hepatitis via tattoos?\_\_\_\_\_\_ Did you get hepatitis vaccine?\_\_\_\_\_\_

Have you ever been exposed to AIDS or had a prior sexually transmitted disease?\_\_\_\_\_\_\_\_\_\_\_\_

Please list any significant stresses or problems you have had in the past year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other issues or concerns that you want the doctor to know that weren’t asked above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advanced TMS Center -- CONSENT FOR MEDICATIONS

I give my consent to take the medications listed below. The medication is being prescribed by

my doctor or clinician to treat a specific emotional disorder. Printed medication information is available at the front office and may also be sent to my Patient Portal. My clinician has explained to me the following:

1. My emotional disorder
2. The reasons for taking the medication, including likelihood of it helping or not helping my condition
3. The other forms of treatment available to me
4. The type, frequency, and amount of medication, as well as method of by which I will take it (by mouth, injection, etc.)
5. An estimate of the length of time I will need to take the medication
6. The common side effects of the medication, including those of stopping suddenly
7. The possible side effects of certain types of medications which may be permanent or irreversible, especially if taken over a long period of time.

# MEDICATION COMPANY HANDOUT PROVIDED? DATE PRESCRIBED Patient Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Yes \_\_\_\_\_\_ not available \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

I understand that I may withdraw my consent at any time by telling my doctor or clinician.

PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

or Legal Guardian: Patient Name Printed Signature Date

LEGAL GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

(if applicable) : Patient Name Printed Signature Date

CLLINICIAN/DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name Printed Signature Date

**Medical Care Contract & Discussion Checklist – ADVANCED TMS CENTER**

**CONFIDENTIALITY:** Legal & ethical responsibilities require all treatment and information therein (Protected Health Information or PHI) be confidential. PHI can only be released to another professional or agency with a separate specific written patient consent or per HIPAA regulations. Some exceptions to confidentiality legally mandate sharing information with specific outside parties; including actual or possible dangerous behavior toward yourself or others, child or elder abuse, some court proceedings, or emergency communication. My signature below gives permission for my clinician to communicate with my primary care or physicians or therapists in emergency situations.

**DOCTOR-PATIENT RELATIONSHIP:** The first appointment is only an evaluation or consultation. At the end of this session, you and the clinician will need to mutually agree whether to (1) proceed and start a clinician-patient (Treatment) relationship (2) schedule another evaluation session before formalizing a Treatment relationship or (3) consider the first session a one-time evaluation and not form an ongoing Treatment relationship. If you and your clinician decide to start treatment, you will both discuss and document specific problems to be addressed, how therapy or treatment will work, agreed upon goals, treatment alternatives, possible treatment outcomes, anticipated difficulties (if any). You have the right to voice any disagreement, distress or concerns about the treatment plan, and request modifications. It is not uncommon to have some negative feelings or responses to treatment, especially in psychotherapy where symptoms sometimes get worse before improving. It’s encouraged to discuss any concerns or negative feelings with your clinician. Your clinician is not required to start a Treatment relationship with you, and will discuss this case with you and offer treatment alternatives as applicable. Either you, or your clinician, can discuss stopping the Treatment relationship at any time, after which you will receive a letter documenting further instructions and that Treatment has ended.

**APPOINTMENTS**: Time is specifically reserved for you by your agreement. To cancel or change an appointment, you must call by the end of one business day BEFORE the day of your scheduled appointment. You must also SPEAK DIRECTLY TO OFFICE STAFF to cancel. **IMPORTANT NOTE: Cancellation left on office or emergency voicemail is NOT valid, and** **will not be accepted. Cancellation without one prior business day notice, or missed appointments will result in you being** **charged a fee, which is currently $75.** Two (2) or more consecutive late cancellations or missed appointments, or excessive appointment changes may result in termination of Treatment. If several months pass without phone contact or an appointment, the Treatment relationship will be considered voluntarily ended by you, and you must call the office to arrange for further treatment. You should receive a letter documenting the end of your treatment here. All efforts are made to see you at the appointed time, but if emergent circumstances, determined by the treating clinician, cause delays, you will still receive your full appointment duration if you stay in the office or online. If you don’t wait a reasonable period of time, a missed appointment fee MAY be charged. Please understand that if you are in a crisis and need extra time, you will be accommodated, just as those before you. Our goal is to minimize wait times.

(add initials) **Your initials indicate that you specifically understand cancellation requirements.**

**STATEMENT OF FINANCIAL ARRANGEMENTS FOR PROFESSIONAL SERVICES**. Please read this financial policy carefully. If your clinician participates (“in-network) with your insurance, you are still responsible for any deductibles, copays and coinsurance. Full payment is expected for **your portion** at the time of service, by ATM, cash, check, money order or credit card. Special arrangements, if necessary, must be discussed in advance, with any exceptions in writing & signed by you and your clinician. It is understood that you are responsible for all charges. If you have no insurance, payment is expected at each visit. Your treating clinician may be an Independent Contractor, and if so, your clinician is solely responsible for all charges to you and/or insurance. At followup visits, you may pay any copayment or coinsurance, & we will bill your insurance for the balance. It is understood, that if for any reason the insurance does not pay the full amount allowed, denies authorization or fails to pay (for example if there is a cap on benefits), then any remaining balance is fully your responsibility. You are required to inform us immediately of any insurance changes, and promptly respond to insurance information requests. If payments are denied because you do not inform us in time to be paid by your new insurance, or you fail to respond to insurance communications, then you will be responsible for payment, even if your clinician is in-network.

Some items are non-covered by your insurance and are listed here. Your signature below indicates you are advised and you agree in advance to be solely responsible for charges for these non-covered services, including: 1. Completion of disability forms, special letters, or other documents (not routine insurance billing). These may also require separate appointments. 2. A $25.00 fee applies for each non-sufficient funds ("NSF" or bounced check) payment, after which future payment must be by cash, or electronic only. 3. Extended or non-emergency phone calls (if not covered by insurance). You will be notified during a call if charges apply. 4. Prescription refills outside of office visits are $10 each. (NOTE: there is never a fee for prescriptions during an office visit). 5. Appointment outside of normal business hours (8:30 to 4:30 Monday-Friday), such as evenings or weekends, will have an additional charge to your insurance company. If your insurance pays, you may owe a copay or deductable on this amount. If your in-network insurance declines the after-hours fee, then you are NOT responsible for it.

**FINANCE CHARGES**: it is clearly understand that any account balance not paid within 30 days after the first statement, accrues monthly interest at 1.5% per month on the unpaid balance until paid in full. After 3 unpaid statements, your account may be sent to an outside collection agency, unless prior payment arrangements are made. The ePAY on our website allows payment plans for up to 18 months with no finance charges.

**EMERGENCY CONTACT PROCEDURES:** your clinician is available by emergency voicemail at 949-768-2988, by following the voicemail prompts, for urgent situations which cannot wait until the next appointment. Leaving an emergency voicemail will automatically page your clinician to return your call. You MUST accept a call from a blocked number for the clinician to call you. It is your responsibility to call your clinician immediately for severe suspected side effects or reactions to medications, suspected pregnancy, severe thoughts of harming yourself or others, or other urgent problems. Major adjustment to medication and psychotherapy cannot be done by phone. Non-emergency calls received during business hours are usually returned the next business day. If your clinician is unavailable, a covering clinician will return emergency calls. For serious emergencies, please call 911 or proceed to the nearest emergency room.

**PATIENT RESPONSIBILITY & PRESCRIPTION REFILL PROCEDURES:** You agree to abstain from excessive alcohol use and use of any outside drugs including marijuana during treatment here. Female patients of child-bearing age must inform the treating clinician of any plans to become pregnant or suspected pregnancy. You also agree to proper behavior in the office and during telehealth visits. The office has a zero-tolerance policy for excessive hostility, foul language, uncontrolled anger, violence or threats of any kind.

To qualify for prescription refills, you must have an upcoming appointment on the schedule first, and your clinician may require you to be seen quickly before issuing a new prescription. Routine prescription refills are NOT considered emergencies, and can take up to 72 hours to complete, so please allow adequate time for refills. Prescription refills are done by ELECTRONIC refill only, so please call here or have your pharmacy send an eRequest. If your Treatment relationship is stopped, your clinician at his/her sole discretion, may issue one final prescription to allow you time to see another provider.

I have completely read, fully understand and agree to the above terms and information, and I consent to treatment at Advanced TMS Center.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal guardian signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician by signing below, indicates that he/she has discussed these issues and answered all patient questions regarding the above information.

Clinician name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_