TMS Therapy
LOUISVILLE

New Patient Information:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

Cell Number: _____ Work Number: _____

Employer: _____ Occupation: _____

Email: _____ May we contact you by email? Yes No

Referring Professional Information:

Referring Provider: _____

Address: _____

Phone: _____ Fax: _____

Emergency Contact:

Contact Name: _____ Relationship to Patient: _____

Phone Number: _____ Cell Number: _____

Insurance Information:

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Subscriber Name: _____ ID Number: _____

For Office Use Only:

Diagnosis Code: _____ Primary Diagnosis Description: _____

TMS Therapy
LOUISVILLE

Treatment History

* Please note that to file for insurance coverage we will need all details of current and past medications for approval of treatment.

Psychotherapy:

Currently in psychotherapy? Yes No

Date therapy started: _____ How often: _____

Type of therapy: _____ Name of therapist: _____

Have you received psychotherapy in the past? Yes No

Name of Provider: _____ Date of treatment: _____

How often: Weekly Bimonthly Monthly

Type of therapy: _____ Name of therapist: _____

Electroconvulsive Therapy (ECT):

☐ Not Applicable

Date of treatment: _____ #of treatments: _____

In a few words describe how you felt the treatment worked for you: _____

_____

Psychiatric Hospitalizations:

☐ Not Applicable

Date of hospitalization: _____ # of Days: _____

Name of Hospital or facility: _____

Date of hospitalization: _____ # of Days: _____

Name of Hospital or facility: _____

Date of hospitalization: _____ # of Days: _____

Name of Hospital or facility: _____

TMS Therapy
LOUISVILLE

Current Medications

Medication Name	Dosage	Medication Start Date

Past Medications

Medication Name	Dosage	End Date

TMS Therapy
LOUISVILLE

TMS New Patient Information Record

Yes	No	If you answer "Yes" to any question please describe below:
		Do you have a cardiac pacemaker?
		Do you have an aneurysm clip?
		Do you have a vagal nerve stimulator?
		Do you have a cochlear implant?
		Do you have any other implanted device?
		Do you have any metallic objects in your body? If yes, please describe:
		Have you ever had any metallic objects in your body? If yes, please describe:
		Do you have cancer?
		Do you have headaches?
		Have you ever had a seizure?
		Have you ever suffered a stroke?
		Have you ever been diagnosed with cardiac disease?
		Do you have any allergies? If yes, please describe:
		Do you have a history of alcohol or drug abuse? If yes, please state when:
		Do you smoke? If yes, how many packs a day? How many years?
		Do you currently drink alcohol? If yes, how many drinks per week?
		Have you ever attempted suicide? If yes, how long ago?
		Have you ever had an MRI of your brain? If yes, for what reason?

Any other medical problems (past or present) not mentioned above, please describe:

_____

_____

Signature: _____ Date: _____

TMS Therapy
LOUISVILLE

Authorization to Release Protected Health Information

Patient Name (First, Middle, Last): _____

Date of Birth (MM, DD, YYYY): _____

Instructions: If any section of this form is incomplete, the form may be invalid.

Release Information From:
(Specify facility/individual & Address, including phone number/fax number if known)

_____

_____

Release Information to:
TMS of Louisville
100 Mallard Creek Road, Ste 210
Louisville, KY 40245

Purpose of Release: Treatment/Continued Care

Information to be Released:

Service Dates: From: _____ To: _____

To include:
- History and Physical
- Clinic notes
- Hospital notes (including discharge summary if applicable)
- Radiology reports/images
- Other:_____

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from the date of signing unless I indicate an earlier date here: _____.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: _____

Signature: _____ **Date:** _____

Patient Consent to TMS Treatment

My doctor has recommended a medical procedure called repetitive Transcranial Magnetic Stimulation or “TMS” treatment for me. This consent form outlines the nature of the TMS treatment, the risks of this treatment, the potential benefits of this treatment, and any alternative treatments that are available if I decide not to receive TMS treatment.

TMS of Louisville has explained the following to me:

What is TMS:

a. TMS stands for “Transcranial Magnetic Stimulation.” TMS treatment is a medical procedure. A TMS treatment session is conducted using a device called the TMS treatment System, which provides electrical energy to a “treatment coil” or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines. The magnetic pulses generate a weak electrical current in the brain that briefly activates neural circuits at the site of stimulation.

b. TMS Treatment has been shown to be a safe and effective treatment for patients with certain mental disorders who have not benefitted from medication or other traditional treatments. The U.S. Food and Drug Administration (FDA) has permitted use of TMS treatment for major depressive disorder and obsessive compulsive disorder. While the FDA may not have specifically approved the use of the TMS system for other disorders, healthcare providers are permitted to use the treatment for an “unapproved” or “off-label” use when the provider considers such treatment is medically appropriate for the patient.

I understand that my treatment is for an _____ approved _____ off-label use (initial one) for the treatment of _____.

Procedure:

a. For each TMS treatment session, I will be brought into a specially equipped room and will be asked to remove any metal or magnetic-sensitive objects such as jewelry, credit cards, etc. Because the TMS treatment system produces a loud click with each magnetic pulse I understand that I must wear earplugs or similar hearing protection devices with a rating of 30dB or higher of noise reduction during treatment for my comfort and safety. TMS does not require anesthesia or sedation, so I will be awake and alert during the entire procedure.

b. A doctor or TMS Center staff member will place the magnetic coil gently over the side or top of my head, depending on the requirements for my treatment. Durning my treatment, I will hear a clicking sound a feel a tapping sensation on my scalp. The doctor will adjust the TMS treatment system so that the device will give just enough energy to send electromagnetic pulses into the brain until there is a slight twitching in my limb- the right hand.

c. The amount of energy required to make me twitch is called the "motor threshold." I understand that everyone has a different motor threshold and the treatments are given at an energy level that is equal to or just above my individual motor threshold. How often my motor threshold will be reevaluated will be determined by my doctor.

Once my motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses," usually with a brief "rest" period. Most protocols have a rest period of 10-20 seconds between each series.

d. Treatment generally takes about 20-45 minutes. I can expect to receive these treatments 5 times a week for 6 weeks, a total of 30 treatments unless my doctor prescribes otherwise. I understand that additional treatments may be required in order for me to receive the greatest benefit from TMS treatment.

Potential Benefits of TMS treatment:

a. My doctor has recommended TMS treatment because it may lead to improvements in the symptoms of my mental disorder. I understand that not all patients respond equally well to TMS, and that some patients recover quickly, others recover briefly and later relates, and others fail to experience any improvement from TMS therapy.

b. I understand that most patients who benefit from TMS Treatment experience results by the fourth week treatment. Some patients may experience results in less time while others may take longer or may not benefit at all.

c. I understand that I may discontinue treatment at any time, although I will remain responsible for payment for treatments I have received.

Risks of TMS Treatment:

As with any medical treatment, there are certain risks involved in receiving TMS treatment.

a. During treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. It is also common to experience facial twitching as well as slight arm/hand twitching. I understand that I should inform

the doctor or the TMS staff if this occurs. The doctor or staff may then adjust the dose or make changes to where the coil is placed in order to help make the procedure more comfortable for me.

b. I understand that it is common to experience headaches related to my treatment. Headaches typically get better over time and generally were relieved with over-the-counter pain medications such as acetaminophen. It is also very common to feel fatigued after treatment.

c. The TMS Treatment System should not be used by anyone who has magnetic-sensitive metal in his or her head that is within 12 inches of the magnetic coil and cannot be removed. **Failure to follow this restriction could result in serious injury or death.** Objects that may have this kind of metal include:

- Aneurysm clips or coils
- Stents
- Implanted Stimulators
- Cardiac pacemakers or implantable cardioverter defibrillator
- Electrodes to monitor your brain activity
- Ferromagnetic implants in your ears or eyes
- Bullet fragments
- Other metal devices or objects implanted in the head
- Facial tattoos with metallic or magnetic-sensitive ink.

d. TMS treatment is not effective for all patients who suffer from _____. If I or those around me notice any negative change in or worsening of my symptoms, or I experience mania or other new symptoms, I will report them immediately to my doctor and/or the TMS center staff. I have been advised to ask a family member, friend or caregiver to monitor my symptoms to help me spot any signs that they have worsened.

e. Occasionally, TMS treatment causes seizures (sometimes called convulsions or fits). I will let my doctor know before my treatment if I have a history of a seizure disorder or if I experience a seizure at any time after my treatment.

f. I understand that if the ear protection devices I must to protect my hearing should become loose or fall out during my treatment, I will notify the person administering my treatment immediately.

g. I understand that the risks of exposure to TMS during pregnancy are unknown. I will inform my doctor before my treatment begins if there is any chance that I may be pregnant.

h. I understand that there may be other unknown risks to the use of TMS treatment and that the long-term effects are not yet known.

i. _____
(Insert any other risks related to the patient's specific illness.)

Other Treatment Options?

A. Other treatment options have been discussed with my doctor for my illness, including _____

_____.

I have read the information contained in this Patient Consent Form about TMS Treatment and its potential risks regarding treatment for my diagnosis of _____. I have discussed TMS treatment with Dr. _____ and TMS of Louisville staff who have answered all my questions to my satisfaction. I understand there are other treatment options for my condition available to me and this has also been discussed with me. I, therefore, permit TMS of Louisville, LLC and its staff to administer a course of TMS treatment to me. If my treatment involves an "off-label" use of TMS, I have been informed of that as well as the particular risks and benefits of such use _____ (initial if applicable). My decision to receive TMS treatment is being made on a voluntary basis. I understand I can withdraw my consent at any time and have the treatments stopped.

Patient Name (Print): _____

Patient SIGNATURE: _____

Witness: _____. Date: _____

TMS Therapy
LOUISVILLE

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. AN example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. AN example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that were have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Office:

- The right to request restrictions on certain uses and disclosure of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W..
Washington, D.C. 20201
202-619-0257
Toll Free 1-877-696-6775

TMS Therapy
LOUISVILLE

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for TMS Partners, LLC.

Printed name: _____

Signature: _____ Date: _____

If the patient is unable or unwilling to sign this acknowledgement, the individual who attempts to obtain the acknowledgment, must describe his or her efforts to obtain it and the reason it was not obtained and must sign below.

_____

_____

_____

Printed Name: _____

Title: _____

Signature: _____ Date: _____

Permission to Leave Messages (optional):

By signing below, I give the staff at TMS of Louisville permission to leave detailed appointment information on my voicemail at the phone number(s) that I have provided to their office. I understand that I have the right to revoke this authorization at any time.

Printed name: _____

Signature: _____ Date: _____

TMS Therapy
LOUISVILLE

Financial Agreement

Patient Information:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Marital Status: _____

Sex: M / F Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ Phone: _____

Policy Holder Name: _____

Member ID #: _____ Group #: _____

SS#: _____ DOB: _____

Relationship to patient: _____

Secondary Insurance: _____ Phone: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____

Office Policy: Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. As a courtesy, we bill most insurance companies. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days from the date of service, the claim will be payable by you. If your insurance requires an authorization or referral for your visit, you are responsible to obtain/ maintain the authorization or referral.

Assignment of benefits: I request that payment of authorized insurance benefits be made on my behalf to TMS Partners, LLC for performed services. I authorize the holder of medical information about me, or any information needed to determine these benefits to be released to the insurance company listed above.

TMS Therapy
LOUISVILLE

For emergencies, please call 911 or go to your local emergency room. If you need to cancel or change your appointment, please do so 24 hours in advance or you could be subject to a missed appointment fee.

Signature: _____ Date: _____

Printed name: _____

Relationship to patient (If signed by someone other than the patient): _____

Witness: _____ Date: _____