New Patient Information Packet:
Northeast TMS

Please fill out and bring with you at your appointment on: ______________________________
at ____________________ with ____

Patient Information

First Name: ____________________________ Middle Initial: _____ Gender: **M** **F**

Last Name: ____

Mailing Address: ____

City: __________________________________ State: _______ Zip Code: _______________

Home Phone: ( ) _________________ SSN:______________________________

Work Phone: ( ) _________________ Birth Date: _________________________

Cell Phone: ( )____________________

Employed by:_________________________________ Position:_______________________

Very Important: Which of these telephone numbers may we use if we need to contact you?

_________________ AND

In the event we need to contact you by telephone, who may we speak with or leave a message with, other than yourself? ____

EMERGENCY CONTACT INFO:____

How were you referred to this office? ____

Patient & Family Information

Please check one: [ ] Single [ ] Married [ ] Divorced

Please check: [ ] Employed [ ] Full-Time Student [ ] Part-Time Student

If Student, please list name of school & grade:______________________________________

List Family Members/Significant Other Names & Ages: ______________________________

____

________(Pt. Initials)

Party Responsible for Payment

**** This section must be filled out with parent information for all patients under the age of 18 ****

First Name: ____ Middle Initial: ______

Last Name: ____

Street Address: ____

City: ___________________________________ State: _______ Zip Code: ________________

Home Phone: (   ) __________________ Work Phone: (   ) _____________________

Signature of Responsible Party: ____

Insurance Information ***(Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service. This section must be filled out completely or we cannot process your claim.)***

Patient's ID #: ____________________ Insurance Company: __________________________

Subscriber's SSN: __________________ (Subscriber is the person who holds the insurance policy.)

Subscriber's Last Name: ____

Subscriber's First Name: _______________________________________ Middle Initial: ______

Patient Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Street Address: ____

City: ___________________________________ State: _______ Zip Code: ________________

Home Phone: (   ) __________________ Work Phone: (   ) __________________

Subscriber's Birth Date: ______________ Subscriber's Employer: ________________________

I hereby authorize Northeast TMS to release any billing information to "Party Responsible for Payment" (Parent or Guardian signature if patient is a minor)

Patient's Signature: _______________________________________ Date: ________________

________(Pt. Initials)

Primary Care Physician

Name of Family Physician: ____

Street Address: ____

City: ______________________________ State: _______ Zip Code: _______________

Work Phone: (   ) _________________ Date of last visit: ______________________

Referral Source Information (If a Professional)

Name ____

Street Address: ____

City: ______________________________ State: _______ Zip Code: _______________

Work Phone: (   ) _________________

Are you currently being treated for any medical illness? If yes, please describe: _____________

____

____

Have you ever been hospitalized for psychiatric reasons? If yes, please list dates and reasons: __

____

____

How has your depression affected your…

work?____

____

social activities?____

____

_________(Pt. Initials)

home responsibilities?____

____

Do you have impairments in (circle all that apply) sleep, enjoyment of activities, motivation, self esteem, energy level, concentration, appetite? Do you feel hopeless/helpless, or have suicidal thinking?

Do you have episodes of very high levels of energy or agitation?___________________________

____

Do you have periods of euphoria that are unexplained by circumstances around you?___________

____

Do you have very erratic mood swings?____

____

Are you currently taking any medications? Please list names and doses.

Drug name	mg in pill	dosing frequency	When started

Past medication history: It is very important to look through your past treatment records (records from pharmacy, personal records, and past medical records from your doctor) to fill out this form. If you are unable to do so, it is unlikely that we will be able to submit a successful claim with your insurance company.

For your convenience, commonly prescribed medications are listed on the next page.

	Max dose	Effectiveness 0-none, 5 great	date/duration at max dose	Side Effects
Prozac/fluoxetine: 20-60				
Paxil/paroxetine 10-50				
Zoloft/sertraline 50-200				
Celexa/citalopram 20-60				
Lexapro/escitalopram 10-40				
Wellbutrin/bupropion 100-450				
Remeron/mirtazapine 15-60				
Effexor/venlafaxine 75-450				
Cymbalta/duloxetine 30-120				
Viibryd 40				
Brintellix 10-20				
Nardil/phenelzine 30-90				
Marplan/isocarboxazid 20-60				
Parnate/tranylcypromine 30-60				

_________(Pt. Initials)

		Max dose	Effectiveness 0-none, 5 great	date/duration at max dose	Side Effects
Emsam/selegiline	6-12				
Risperdal/risperidone	0.5-6				
Abilify/aripiprazole	2-30				
Latuda	20-160				
Fanapt	6-12				
Saphris	10-20				
Invega	3-12				
Seroquel/quetiapine	50-800				
Geodon/ziprasidone	20-240				
Lamictal/lamotrigine	50-600				
Lithium/eskalith/ Lithobid	300-1800				
Cytomel/liothyronine	12.5-50 mcg				

_________(Pt. Initials)

Have you tried imipramine/Tofranil, amitriptyline/Elavil, nortriptyline/Pamelor, clomipramine/ Anafranil, desipramine/Norpramin, amoxapine/Asendin, doxepin/Sinequan?_______________

____

____

Are there any other medications you have tried for depression __________________________

____

Have you undergone ECT?____

If so, how many treatments, how effective, and what side effects were experienced?____________

____

Have you seen a psychiatrist for medication in the past? Who? When?_______________

____

____

____

Have you ever seen a counselor/psychotherapist before? If so, please list names and dates of treatment, counselor, focus of treatment, type of counseling (cognitive behavioral therapy, psychodymanic therapy, cognitive therapy, EMDR, DBT, etc.)

____

____

____

____

____

Has anyone in your family had emotional or psychiatric problems? If yes, please describe: _____

____

____

____

PROVIDER – PATIENT SERVICES AGREEMENT

This document (the Agreement) contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you are provided with a Notice of Privacy Practices (the Notice) which you can receive with this agreement, for the use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires your signature acknowledging that you have been provided with this information at the start of treatment. When you sign this document, it will represent an agreement. You may revoke this Agreement in writing at any time. That revocation will be binding unless action has already been taken in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Office Hours and Emergency Contact

Office hours are variable for the TMS service, but the technician will be checking for voice mail messages regularly. Dr. Naimark and Dr. Schmidt are often in the office seeing patients even when the technician is not in the office. If you call after hours and have an emergency which cannot wait until the office opens, you will be instructed on the message how to reach Dr. Naimark or Dr. Schmidt through the answering service. Phone calls to Northeast TMS should pertain only to TMS issues. All other psychiatric concerns should be addressed to your primary psychiatrist. If you have a serious emergency that cannot await a call back, please go the nearest emergency room.

Late Cancellation/Missed Appointments

Your appointment reserves your provider's time. Once an appointment is scheduled, you will be expected to pay for the session if it is cancelled unless you provide ***24 business hours*** advance notice of cancellation**. (*For example, to cancel an appointment for 9AM on Monday, you would need to call before 9AM the previous Friday.)*** These charges cannot be billed to your insurance company. Please help us serve you better by keeping scheduled appointments and calling the office ***at least 24 business hours*** prior to your appointment time if you must cancel.

Pt. Signature___________________________

Confidentiality

A. General

In order for therapy to be successful, it is often necessary to safely reveal private, sensitive information about yourself in the course of treatment. Ethically and legally, all of us here are bound to keep all of this information strictly confidential. The law protects the privacy of all communications between a patient and a clinical provider. In most situations, information about your treatment cannot be revealed to others unless you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

Occasionally it may be helpful to consult other health and mental health professionals about a case. During a consultation, your identity is usually not revealed. The other professionals are also legally bound to keep the information confidential. All consultations will be noted in your Clinical Record.

The practice has other mental health professionals and administrative staff. In most cases, protected information will be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a clinical provider.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
There are certain conditions under which confidentiality may be breached:

- If a patient threatens to harm himself/herself, there may be an obligation to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If you disclose that a child or an elderly person is being sexually or physically abused, it must be reported to the proper authorities.
- If you are a danger to yourself or someone else, whatever is necessary to protect you and/or the other person must be carried out. The other person would have to be warned and the police notified.

_________(Pt. Initials)

In legal proceedings, the courts usually respect your rights to confidentiality in the therapeutic relationship, and there is an ethical bond to protect that right when testifying in legal or administrative proceedings. However, a judge could court order testimony in certain situations, such as a contested custody proceeding in a divorce and, under these circumstances, we must do so.

- If a government agency is requesting the information for health oversight activities, it may be required to be provided.
- If a patient files a lawsuit, relevant information regarding the patient will be disclosed for an appropriate defense.

Whenever possible, any imminent breaches of confidentiality will be discussed with you before taking any action and will be limited to the minimum necessary.

It is our practice to consult with colleagues within the practice regarding clinical matters and on-call coverage. Full confidentiality, therefore, cannot be maintained within our group of clinicians, although the information shared is only the minimum necessary for the consultation or to insure effective clinical intervention. If you know someone within the practice in a nonprofessional capacity, please inform me right away. Your treatment will not be discussed with, or in the presence of, that person.

B. Professional Records and Patient Rights

The laws and standards of my profession require that Protected Health Information be kept about you in your Clinical Record. HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your record be amended; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and privacy policies and procedures. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in the presence of your provider, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, there is a copying fee of $15.00 for the first 30 pages or 50 cents per page, whichever is greater .

C. Office Policies

All administrative and office staff are bound to confidentiality and cannot disclose any information. This becomes especially sensitive when relatives call the office requesting even simple information, such as an appointment time for their spouse. Even under these simplest of situations, the office personnel cannot acknowledge that they even know the person, nor can they disclose any information. If ongoing contact is to occur with a relative, regarding billing for example, then a release of information form can be signed, specifying the information that is permitted to be exchanged. All requests for records must be accompanied by a signed release of information. It is our office policy to keep records for 10 years from the date the record becomes inactive.

Insurance Reimbursement and Patient Balances

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We accept assignment of insurance benefits from most insurance companies for your primary insurance only. However, we do require that deductibles and co-payments be paid in full at the time of service. The balance is your responsibility whether your insurance company pays us or not. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance automatically becomes your responsibility. Please be aware that in some cases the services provided may be considered non-covered services by your insurance plan. Delinquent accounts must be paid in full before another session can be scheduled. Delinquent accounts may require further action.

You should carefully read the section in your insurance coverage booklet that describes mental health services. Your coverage, co-payments, and benefits could be quite different from your regular medical coverage. If your insurance plan includes a managed care component, you may be required to obtain preauthorization and your coverage may be limited. It is your responsibility to contact your insurance company to determine if preauthorization must be obtained by you prior to your treatment.

You should also be aware that most insurance agreements require you to authorize me to provide basic clinical information such as diagnosis and treatment plans. Occasionally an entire copied record is required. While it is our policy to release only the minimum necessary information required to activate your insurance benefits, you need to be aware that we cannot control its use by your insurance company. Any concerns you may have about confidentiality of managed care records should be directed to the managed care company.

Some insurance companies require that billing and other information be sent electronically (e.g., by facsimile or e-mail). The confidentiality of such communications cannot be guaranteed. If you do not consent to electronic communications, please inform the office immediately, before beginning treatment, so that we can determine whether and how to proceed. Once information about your insurance coverage has been determined, it is important for you to discuss with your clinical provider what can be accomplished with the benefits that are available, and what will happen should your benefits expire before you feel ready to end treatment. It is important to remember that you always have the right to pay for services yourself and not involve your health insurer at all.

D. Cost of Services

Service	Cost
Initial Psychiatric Evaluation	$300.00
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	$600.00
Subsequent delivery and management, per session	$300.00
Subsequent motor threshold re-determination with delivery and management	$600.00
Evaluation and management, low complexity	$95.00
Evaluation and management, medium complexity	$140.00
Evaluation and management, high complexity	$180.00
Appointment missed without 24 hours notice	$100.00

It is crucial that attendance of TMS sessions be fulfilled as recommended. Missing or canceling appointments will seriously jeopardize treatment success. If treatment sessions are not regularly attended, treatment will likely be terminated before completion.

We bill at $300 per hour for ancillary services such as preparing for and participating in legal matters relating to your treatment. A retainer, in advance, is required prior to undertaking such services. By signing this form you agree to pay for such services when you request them.

________(Pt. Initials)

In Closing

It is important that you understand and are comfortable with the issues outlined above. Please bring up, in your first treatment session, any questions or concerns you might have.

Please Sign

I have read and accept the terms outlined on the prior pages of this form.

-- -------------------------------------
Signature of patient or legal representative Date

-- -------------------------------------
Signature of patient or legal representative Date

CONSENT TO RELEASE INFORMATION

I authorize my clinical provider to release and exchange medical information as necessary to my insurance carrier, my primary care physician, and a referring physician or therapist.

I understand I am responsible for contacting my insurance company for benefit coverage and preauthorization (if needed) prior to the day of treatment. I will provide this information to my clinical providers office (the Office) at the time of my first appointment. I will provide current information regarding my insurance throughout my course of treatment.

I understand that my insurance will be billed by the Office with the proper information provided.

I understand that this does not guarantee insurance payment to the clinical provider and that any outstanding balance is my responsibility.

I understand that regardless of insurance coverage, I must settle my account within sixty (60) days.

I further understand that I may revoke this authorization at any time should I desire by notifying this office in writing.

Name of Patient: ____

Signature of Patient or Legal Representative: ____

Date: ____________________________

Signature of Provider :_______________________________ Date: ________________________

Receipt of HIPAA Notification and Bill of Rights____________________________Date:______

________(Pt. Initials)