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 Message: Yes / No
work #: (_____) _____
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

I wish to be contacted in person or by message at the following number(s): _____
(**circle Yes or No**):

Y	**N**	**Appointments**	**Y**	**N**	**Medication concerns**
Y	**N**	**Labs**	**Y**	**N**	**Other (i.e. billing, insurance, etc.)**

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

Date: _____ Signature:_____ Print Name:_____

Advanced TMS Center
333 Corporate Drive #260
Ladera Ranch CA 92694

Ph 949-768-2988
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:_____

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:_____

_____

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:_____

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:

a) My emotional disorder

b) The reasons for taking the medication, including likelihood of it helping or not helping my condition

c) The other forms of treatment available to me

d) The type, frequency, and amount of medication, as well as method of by which I will take it (by mouth, injection, etc.)

e) An estimate of the length of time I will need to take the medication

f) The common side effects of the medication, including those of stopping suddenly

g) 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	_____	____

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 – ADVANCED TMS CENTER

333 Corporate Drive, Suite 260, Ladera Ranch, CA 92694 Phone (949) 768-2988

CONFIDENTIALITY: Legal & ethical responsibilities require all treatment be confidential. Pertinent clinical information will only be released to another professional or agency with a separate specific written consent. Some exceptions require bylaw information be shared with specific outside parties, including actual or possibly dangerous behavior towards yourself, towards others, child or elder abuse, or some court proceedings. My signature below gives permission for my physician or Nurse Practitioner to communicate with my primary care or physicians or therapists in emergency situations.

APPOINTMENTS: Time is specifically reserved for you by your agreement. To cancel or change an appointment, you must call by the end of the 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 business day's notice, or missed appointments will result in you being charged a fee.** Two (2) or more late cancellations or missed appointments, or excessive appointment changes may result in termination of treatment. If more than six (6) months passes without phone contact or an appointment, the doctor-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, but 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 who went before you. Our goal is to have wait times under 15 min. **Please initial here that you understand these cancellation requirements:_____.**

STATEMENT OF FINANCIAL ARRANGEMENTS FOR PROFESSIONAL SERVICES RENDERED. Please read this financial policy carefully. If your clinician is participating ("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 with us 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, however, 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. Some items are non-covered by your insurance and are listed here. By signing you are advised and you agree in advance that you are solely responsible for charges for these non-covered services, which include: 1. Completion of disability forms, special letters, or other documents (not routine insurance billing), and 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, ATM or credit card only. 3. You may be charged for extended or non-emergency phone calls (usually not covered by insurance). You will be notified during a call if charges apply. 4. Prescription refills by phone or fax outside of office visits are charged at $10 each. (NOTE: there is never a fee for prescriptions during an office visit). 5. If your appointment is outside of normal business hours (8:30 to 4:30 Monday-Friday), such as evenings or weekends, an additional charge will be made to your insurance company. If your insurance pays, you may owe a copay or deductable on this amount. If your in-network insurance forbids us to charge you for this after-hours fee, then you are NOT responsible for it.

FINANCE CHARGES: I clearly understand any balance on your account that is not paid within 30 days from statement postmark, will accrue monthly interest at the rate of 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. We have ePAY on our website which allows payment plans for up to 18 months with no finance charges.

EMERGENCY CONTACT PROCEDURES: your doctor is available by emergency voicemail at 949-768-2988, by following the voicemail prompts, for urgent situations which cannot wait until the next appointment, and he/she will be automatically paged to return your call. You MUST accept a call from a blocked number for the doctor to call you. Call the doctor 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. You agree to abstain from excessive alcohol use and drugs including marijuana during treatment here. To qualify for prescription refills, you must have an upcoming appointment scheduled first. Non-emergency calls received during business hours are usually returned the next business day. If your clinician is unavailable, a covering clinician will return urgent calls. For serious emergencies, please call 911 or proceed to the nearest emergency room. Prescription refills are done by ELECTRONIC refill only, so please call here or have your pharmacy send an eRequest.

I have completely read, fully understand and agree to the above terms and information.

Dated: _____ _____ _____

Signature of Patient or legal guardian Patient name PRINTED

Advanced TMS Center -- TREATMENT CONSENT DISCUSSION CHECKLIST

DATE DISCUSSED	CLINICIAN INITIALS	SUBJECT
_____	_____	1. Specific problems to be addressed
_____	_____	2. Agreed upon goals (patient/therapist expectations), abstaining from drugs/alcohol during treatment
_____	_____	3. How therapy or treatment will work
_____	_____	4. Possible outcomes
_____	_____	5. Anticipated difficulties, if any
_____	_____	6. Right to voice disagreement, distress, etc.
_____	_____	7. Expectation of some negative feelings or responses
_____	_____	8. Emergency situations and how to deal with them: ____ suicidal or homicidal thoughts—call office at 949-768-2988 during or after business hours ____ prescription refills are NOT emergencies, & there must first be a future appointment on the schedule. The pharmacy must request a RF electronically
_____	_____	9. Alternatives to anticipated therapeutic approach
_____	_____	10. Exceptions to confidentiality: ____ A. Duty to warn or protect endangered parties ____ B. Child or elderly abuse ____ C. Bringing own mental status before court as an issue ____ D. Emergency communication with another clinician
_____	_____	11. Business arrangements: ____ A. Missed appointments, or cancelled after 5 pm the business day preceding appointment, current fee: $75 ____ B. Finances (insurance, collection of unpaid bills, authorizations) ____ C. Emergency phone coverage for doctor's illness or vacation ____ D. Special forms, letters, Rx outside office visits, extended phone fees
_____	_____	12. Termination of doctor-patient relationship

My signature below means that I consent to treatment at Advanced TMS Center**. I understand that the initial evaluation is a consultation ONLY, and both I and my clinician need to agree to formally begin a clinician or doctor-patient relationship for treatment after the initial evaluation. My clinician will discuss this with me and offer treatment alternatives as applicable.**

_____	_____	_____
DATE	PATIENT signature	PATIENT NAME—PRINTED
_____	_____	_____
DATE	Legal Guardian signature	Legal Guardian Name—PRINTED

_____
Clinician or Doctor's Signature

AUTHORIZATION FOR RELEASE OF RECORDS and/or COLLABORATION
Advanced TMS Center 333 Corporate Drive #260 Ladera Ranch CA 92694

This document authorizes:

1. _____
_____
_____
Phone:_____ Fax: _____

2. _____
_____
_____
Phone:_____ Fax: _____

To: ___communicate reciprocally with Advanced TMS Center, any provider
___disclose & send information marked below to Advanced TMS Center
___receive information from Advanced TMS Center

The following medical records are also requested as indicated below:

__ Hospital discharge summaries and medication lists from the past ___ years.

__ Lab, EKG, xray and neuroimaging data from the past ___ years.

__ Please send NEW, FUTURE laboratory, EKG & neuroimaging results, until further notice.

__ Any and all prior psychiatric, mental illness, psychological testing, psychotherapy, and substance abuse records.

__ Genetic Testing

__ Routine progress notes are NOT required unless they pertain to psychiatric treatment

__ Psychotherapy notes are NOT requested.

__ Other:_____
_____

SEND RECORDS BY *FAX ONLY* (HIPAA compliant secure Fax connected directly to EMR) TO:

Advanced TMS Center
Fax: (949) 768 – 2980
Mailing address: PO Box 7450 Laguna Niguel CA 92607
Phone: (949) 768-2988

Signed:_____ Date:_____

Patient Name (printed):_____ Patient Birthdate:_____

Witness signature:_____

NOTE: This authorization remains valid until withdrawn in writing by patient or guardian. A copy or fax of this authorization will be deemed as valid as the original. Note: records may be subject to re-release, as receiving parties may not be bound by HIPAA rules. Please call us at 949-768-2988 if there are further questions or problems.