ADVANCED TMS CENTER

Kevin M. Kinback, MD
Janet A. Smith PMHN-BC, DNP
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.

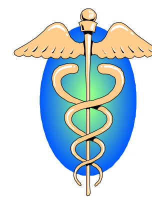
NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov
Kevin Kinback, MD., Board Certified Psychiatrist

Nurse practitioners are licensed and regulated by the California Board of Registered Nursing
(916) 322-3350
www.rn.ca.gov
Janet Smith PMHN-BC, DNP

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	______________	____
__________________	_______ 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
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 business hours, or voicemail at 949-580-6122 **after** business hours ____ prescription refills are NOT emergencies, & there must first be a future appointment on the schedule. The pharmacy must fax 949-768-2980.
_______	________	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 or Legal Guardian signature

__________________________ PATIENT NAME—PRINTED

_______________________________ Clinician or Doctor's Signature