Northern TMS
TRANSCRANIAL MAGNETIC STIMULATION
www.NorthernTMS.com

PATIENT INFORMATION

TODAY'S DATE	ARE YOU A NEW PATIENT? ☐Yes ☐No	FOR PROVIDER USE ONLY: CHECK OFF LIST DX:_____ ☐Card Copies (*front & back*) Attached ☐Insurance Verification From Attached ☐Authorization Attached (*if applicable*)
FIRST NAME MIDDLE NAME LAST NAME		
MAILING ADDRESS CITY STATE ZIP		
HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -
E-MAIL ADDRESS *(OPTIONAL)*	BIRTHDATE / AGE	SEX ☐M ☐F / ETHNICITY *(OPTIONAL)*
		MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
EMPLOYMENT STATUS ☐Full-Time ☐Part-Time ☐Retired ☐None ☐Self Employed ☐Active Military		STUDENT STATUS ☐Full-Time ☐Part-Time ☐None

RESPONSIBLE PARTY INFORMATION

(Only IF Different from Patient Information Above)

FIRST NAME MIDDLE NAME LAST NAME		
BILLING ADDRESS CITY STATE ZIP		
HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -
RELATIONSHIP OF PATIENT TO RESPONSIBLE PARTY ☐Spouse ☐Child ☐Other (Specify)_____		

INSURANCE INFORMATION

(Please Provide Copies of ALL I.D. Cards – FRONT and BACK, If Applicable)

☐Please Check Here If You Have No Insurance And You Will Be Solely Responsible For Payment (*Skip to the next page*).

PRIMARY INSURANCE NAME			SECONDARY INSURANCE NAME		
INSURANCE PHONE NUMBER ( ) -	EFFECTIVE DATE		INSURANCE PHONE NUMBER ( ) -	EFFECTIVE DATE	
CLAIMS ADDRESS			CLAIMS ADDRESS		
CITY STATE ZIP			CITY STATE ZIP		
SUBSCRIBER'S NAME	SEX M☐F☐	DATE OF BIRTH	SUBSCRIBER'S NAME	SEX M☐F☐	DATE OF BIRTH
SUBSCRIBER'S I.D. #	GROUP #		SUBSCRIBER'S I.D. #	GROUP #	
SUBSCRIBER'S EMPLOYER	DEDUCTIBLE $	COPAYMENT $	SUBSCRIBER'S EMPLOYER	DEDUCTIBLE $	COPAYMENT $
RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐Self ☐Spouse ☐Child ☐Other _____			RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐Self ☐Spouse ☐Child ☐Other _____		

FOR WORKERS COMPENSATION INSURANCE ONLY, PLEASE SPECIFY

Date of Injury _____ State in Which Injury Occurred _____

CONSENT TO DISCLOSE ACCOUNT INFORMATION

According to State and Federal confidentiality laws, we cannot disclose any information about you to any other person without your consent. This includes other family members, unless you are less than 18 years old or under certain legal circumstances.

I understand that "information" includes activities involved in determining my eligibility for health plan coverage, billing and receiving payment from myself and from my health insurance plan, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

I authorize this medical provider to disclose details of my account and my care to the following person(s) to ensure that payment is received for the services rendered to me.

☐ ***PLEASE CHECK HERE IF YOU DO NOT WISH ANYONE ELSE TO HAVE ACCESS TO YOUR FINANCIAL INFORMATION.***

FIRST NAME MIDDLE NAME LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
FIRST NAME MIDDLE NAME LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN NAME			PHYSICIAN PHONE
			( ) -
PRIMARY CARE PHYSICIAN ADDRESS (IF KNOWN)	CITY	STATE	ZIP

MAY WE CONTACT YOUR PHYSICIAN SO THAT THIS PROVIDER MAY BE FULLY INFORMED AND WE MAY COORDINATE YOUR TREATMENT?

☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE	WORK PHONE	CELL PHONE
( ) -	( ) -	( ) -

HOW DID YOU HEAR ABOUT US?

☐ Doctor Referral	☐ Insurance Company	☐ Magazine or News Article	☐ Yellow Pages
☐ Friend or Relative	☐ Internet or Web Site	☐ Television	☐ Other _____

NAME / DETAILS	PHONE NUMBER	MAY WE CONTACT THIS PERSON?
	( ) -	☐ Yes ☐ No

POLICY STATEMENT

Thank you for choosing our office for your psychiatric needs. We are committed to your treatment being successful. Please understand that payment of your services is considered part of your treatment. The following sets forth the terms and conditions upon which our services are rendered.

CONSENT OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: I hereby consent to the use or disclosure of my protected health information by for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis and treatment of me is conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this medical practice. The doctor is not required to agree to the restrictions that I may request. However, if this office agrees to any restriction that I request, then this restriction is then binding. I have the right to revoke this consent, in writing, at any time, except to the extent that the doctor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by this provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected

health information relates to my past, present or future physical health, mental health or condition, and identifies me, or if there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the doctor's Notice of Privacy Practices prior to signing this document. A copy of this Notice of Privacy Practices is available upon my written request.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties with respect to my protected health information.

I understand that this medical office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting it in writing, either by mail or at my next appointment, and a revised copy be sent in the mail or will be provided to me at the time of my next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to, abuse of minor or elder, or if you express the intent of bringing harm to yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities.

PAYMENT OF FEES: Payment for services is the patient's responsibility. I agree to pay my share of the charges, such as co-payment and deductible amounts, at the time of each visit. The charge for each appointment depends upon the time I spend with the physician, and the type of visit for which I am seen. For specific dollar amounts, please ask the office staff. Please note that this office charges a $25 service fee for all returned checks.

INSURANCE: This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true.

PRIOR AUTHORIZATION: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s).

APPOINTMENTS: Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment with at least 24 hours advance notice I will be charged up to $120.00 each time. I understand that insurance companies do not cover missed appointments.

MEDICAL RECORDS: I understand that the doctor will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to the authorized party.

MEDICATIONS: I understand if I should need to have a prescription refilled that I should contact my pharmacy at least 3 business days prior to needing the medication or the medication may not be available to me the same day. I understand refills for any medication will not be performed unless I have been seen within the last six months.

AGREEMENTS: I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by me.

I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered. In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90-days from the date the claim was submitted, I agree that I will become responsible for the full amount of the balance on my account. Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure.

I also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs.

I have read this Policy Statement and agree to the terms as stated:

_____ _____

Patient Signature **Date**

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Financial Policy

There are two components to the provision of Transcranial Magnetic Stimulation ("TMS") therapy that are reflected in the costs to you:

Initial Consultation: Before TMS therapy is administered, you will receive an initial consultation to determine if TMS is appropriate for you. The cost of the initial consultation is **$250** and is due regardless of whether you proceed with TMS therapy. Depending on the terms of your specific mental health insurance policy, the initial consultation may be covered by insurance, and your insurance carrier may reimburse you. As a courtesy, we will submit a claim to your insurance carrier if you would like us to do so. Any balance left by insurance will become patient responsibility.

Transcranial Magnetic Stimulation ("TMS") therapy: TMS therapy is provided by Northern TMS. The cost for the initial course of therapy may vary depending on the treatment protocol prescribed for you. On average, the course of treatment will range from $8,000 to $12,000 for 20-30 sessions. Additional treatments may be required for maximum benefit. Additional treatments are $550 for Motor Threshold Measurement and $400 per additional treatment session**. Before treatment begins, a down payment of at least $500 is required.**

Insurance Coverage and Reimbursement for TMS Therapy: Many insurers provide coverage for TMS therapy based on specific conditions and treatment protocols. We will help you contact your insurance company, verify benefits and determine coverage based on your diagnosis and specific benefit plan. Our billing staff will assist you in submitting your claims to your insurance company for reimbursement. **Please understand, however, that you are responsible for <u>all</u> charges incurred. A referral from your physician, pre-certification of insurance coverage, and recommendations for TMS therapy, among other things, do not guarantee insurance payment.**

Payment will be collected in biweekly installments during the course of therapy for all self-pay, out-of-network and off label care, regardless of whether we assist you in filing with your insurance carrier. A credit card will be kept on file and will be charged if insurance does not pay for treatment. In most cases, **a $500 down payment will be required before treatment can begin**.

If the TMS Center contracts with your insurance carrier: In cases where Northern TMS has a contract with your insurance carrier, we will bill your carrier in accordance with the terms of the contract. We will collect all co-pays, co-insurance, non-covered service charges and deductibles from you at the time of service.

Denial of Coverage: If coverage of TMS therapy is denied and you would like to appeal the denial, your insurance carrier may require a letter of medical necessity. We will furnish the letter upon your request. Please be aware that our charge to insurance may differ from our charge for our self-pay patients. If your insurance carrier ultimately approves coverage of TMS therapy, we must collect any copayments, co-insurance and deductibles required under your insurance plan.

Payment for TMS Therapy: The patient is responsible for payment for TMS therapy (see above regarding filing for insurance reimbursement). We accept most forms of payment. Payment for TMS therapy should be made to "Northern TMS". Returned checks will be charged the entire amount plus a $25 return check fee.

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Cancellation policy: In order for TMS therapy to be effective, it should be performed on a routine basis for a minimum of 20 sessions/4 weeks (treatment is generally scheduled M-F). **Missing any treatments could affect your response and is not advisable. There are no refunds for missed treatments.**

We will refund payment **ONLY** if we receive notice at least seven (7) days before the date your initial (acute phase) treatment is scheduled to begin. **No refunds** will be given after this time.

Patient acknowledgement:

I have read the above financial policy and have been given an opportunity to ask questions and my questions have been answered to my satisfaction. A copy of this form has been made available to me.

_____ _____

Patient Signature Date

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Consent for Transcranial Magnetic Stimulation

This is a patient consent for a medical procedure called Transcranial Magnetic Stimulation (TMS). This consent form outlines the treatment that your doctor has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you, and any alternative treatments that are available for you if you decide not to be treated with TMS.

Dr. Anderholm has told me that I have the following condition(s):

___Major Depressive Disorder:_____

The doctor has explained to me that:

a. A TMS treatment session is conducted using a device called a “treatment coil” or magnet that delivers pulsed magnetic fields. These magnetic fields are of a similar type and strength as those used in magnetic resonance imaging (MRI) machines.

b. TMS is a safe and effective treatment for patients with depression.

c. Specifically, TMS has been shown to relieve depressive symptoms in adult patients who have been treated with one antidepressant medication given at a high enough dosage and for a long enough period of time but did not get better.

d. At this time, the FDA approved indication for TMS does not include patients who did not get better after taking two or more antidepressant medications at a high enough dose and for a long enough period of time or who did not take any antidepressants during this current period of depression.

e. During a TMS treatment session, the doctor or a qualified member of the clinic staff will place the magnetic coil gently against my scalp on the front region of my head. The magnetic fields that are produced by the magnetic coil are pointed at a region of the brain that scientists think may be involved with depression.

f. To administer the treatment, the doctor or a qualified member of the clinic staff will first position my head in the head support system. At the first session, a procedure will be done to establish the appropriate stimulation dose. The magnetic coil will be placed on the side of my head, and I will hear a clicking sound and feel a sensation on my scalp. The doctor will then adjust the TMS coil so that the device will give just enough energy to send electromagnetic pulses into the brain so that my hand twitches. The amount of energy required to make my hand twitch is called the “motor threshold.” Everyone has a different motor threshold, and the treatments are given at an energy level that is related to my individual motor threshold. The motor threshold procedure takes about 20-30 minutes, and my doctor will determine how often it is re-evaluated or repeated.

g. Once the motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses" lasting commonly around 5 seconds with a "rest" period of about 15-30 seconds between each pulse series. Treatment is to the front side of my head and will take about 40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. I will receive these treatments 5 times a week for approximately 4-6 weeks (20-30 treatments). My doctor will evaluate me at least weekly during this treatment course. The treatment is designed to relieve my current symptoms of depression. The doctor may modify these treatment parameters, such as adding additional treatments or stimulating a different place on my head, or the other side of my head.

h. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one-third of the patients who participated in the research studies. I may also experience muscle contractions around the site of stimulation. I may also experience tooth pain with stimulation. I understand that I should inform the doctor or staff if the sensation is painful. The doctor may then adjust the dose or make changes to the location where the coil is placed in order to help make the procedure more comfortable for me. I also understand that headaches were reported in half of the patients who participated in a recent clinical trial for a TMS device. I understand that both the discomfort and headaches got better over time in the research studies and that I may take common over-the-counter pain medications if a headache occurs.

i. The following risks are also involved with this treatment: TMS should not be administered to anyone who has magnetic-sensitive metal in their head or magnetic-sensitive metal within 12 inches of the TMS coil that 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

□ Carotid or cerebral stents

□ Implanted stimulators

□ Electrodes to monitor your brain activity

□ Ferromagnetic implants in your ears or eyes

□ Bullet or shrapnel fragments

□ Other metal devices or objects implanted in the head

□ Pellets, bullets, or metallic fragments <12 inches from coil

□ Magnetically activated dental implants

□ Facial tattoos with metallic ink

j. There is no guarantee that this treatment will improve my condition as TMS is not effective for all patients with depression. Any signs or symptoms of worsening depression or unusual behavior or thoughts should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression or unusual behavior.

k. Seizures (sometimes called convulsions or fits) have been reported with the use of TMS devices. There were no seizures in the NeuroStar clinical trials, which involved over 10,000 patient treatment sessions. In a recent large multi-center clinical trial, no seizures were observed with use of TMS for ~300 patients. However, seizures have occurred during other research and clinical use of TMS. Although the risk of having a seizure is quite low, complete medical information must be provided to your doctor so that your level of risk can be assessed and discussed with you. The current estimated risk of seizure is 1 in 30,000 treatments (0.003%) or 1 in 1,000 patients (0.1%).

l. Because TMS 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.

m. I understand that most patients who benefit from TMS experience results by the sixth week of treatment. Some patients may experience results in less time, while others may take longer.

n. I understand that I may discontinue treatment at any time.

o. Off-label uses: The term “off-label” refers to the absence of FDA clearance or approval for a device or medication. Pharmaceutical companies and device manufacturers are not allowed to promote a product for any other purpose then what was studied in the FDA trials. However, once a drug or device has been approved for sale for one purpose, physicians are allowed to prescribe it for any other purpose that in their professional judgment is both safe and effective, and are not limited to FDA-approved indications. Commonly used off-label uses for TMS include extended protocols and/or bilateral treatments. You will be notified if off-label protocols are being used during your treatment.

p. Research: Northern TMS would like permission to use anonymous data regarding treatment parameters and responses to treatment as part of research efforts to better understand how to maximize the use of TMS. This only applies to data generated during routine clinical care. If you are involved in any formal research projects, a separate consent will be included in that process. When the results of research are published or discussed in conferences, no information will be included that would reveal your identity. If you decide to take part in this type of study, you are free to withdraw at any time without giving a reason. This will not affect the relationship you have with the researcher or treatment provider. **If you do not want data generated during your treatment used in this way, initial here _____.**

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I have read the information contained in this consent form about TMS and its potential risks. I have discussed it with Dr. Anderholm who has answered all of my questions. I understand there are other treatment options for my depression available to me including medications, psychotherapy, and other brain stimulation treatments like electroconvulsive therapy (ECT). These alternative treatment options were discussed with me.

I therefore permit Dr. Anderholm or staff to administer this treatment to me.

By signing below, I understand that all initialed parts of this document act as my signature. I understand that by typing my name on the signature line below acts like an e-signature and is legally binding.

_____ _____

Patient's Signature Date