ADVANCED TMS CENTER

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

Today's Date: _____

PATIENT

Name: _____ Referred by: _____

Home Address:_____ City:_____ Zip: _____

Telephone Numbers: home #: _____ Cell #: _____ Okay to Leave Message: Yes / No

Work #: _____ Email: _____

Pharmacy Name: _____ Pharm. Address:_____ Pharm. Phone: _____

Employer's name & address: _____

Social Security #: _____ Date of Birth: _____ Single / Married / Divorced

Driver's License #: _____ Name of Nearest Relative:_____

Nearest Relative's Address & Phone: _____

INSURANCE

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: _____

Print Name: _____ Signature: _____

Note: Providers located at Advanced TMS Center are all independent contractors. Providers are unable to guarantee a specific outcome or treatment result. I understand that California Law requires me to be physically located in California to be able to participate in a telehealth visit. It is the patient's sole responsibility to verify whether their provider participates in their insurance network.

Acknowledgement of Notice of Privacy Practices Advanced TMS Center PATIENT CONSENT FORM (protected health information or "PHI")

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Advanced TMS Center. This Notice informs you about how we may use and disclose your PHI. We encourage you to read it in full. This Notice is subject to change. The Notice of Privacy is available on our website **AdvancedTMSCenter.com** and in our office. You may request a copy of the Notice of Privacy. By signing below you give consent for your doctor to view external medication history for the electronic prescription (eRx) process, and to check your insurance coverage for future prescriptions.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint, go to www.mbc.ca.gov, email: licensecheck@mbc.gov, or call (800) 633-2322.

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 To check the status of your physician and surgeon D.O. License online, go to https://search.dca.ca.gov/. To file a complaint against the physician and surgeon D.O., complete the online complaint form on the Osteopathic Medical Board of California website or email: osteophathic@dca.ca.gov.

NOTICE TO CONSUMERS: The Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints you may contact the Board on the Internet at www.psychology.ca.gov, by emailing bopmail@dca.ca.gov, calling 1-866-503-3221 or writing to the following address: Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834

NOTICE TO CLIENTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

Signature of Patient : _____ Date : _____

Name of Patient (please print): _____

Signature of Guardian : _____ Date : _____

Name of Guardian/ Patient Representative (please print):_____

Relationship to Patient: _____

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 & Discussion Checklist – ADVANCED TMS CENTER

CONFIDENTIALITY: Legal & ethical responsibilities require all treatment and information therein (Protected Health Information or PHI) be confidential. PHI can only be released to another professional or agency with a separate specific written patient consent or per HIPAA regulations. Some exceptions to confidentiality legally mandate sharing information with specific outside parties; including actual or possible dangerous behavior toward yourself or others, child or elder abuse, some court proceedings, or emergency communication. My signature below gives permission for my clinician to communicate with my primary care or physicians or therapists in emergency situations.

DOCTOR-PATIENT RELATIONSHIP: The first appointment is only an evaluation or consultation. At the end of this session, you and the clinician will need to mutually agree whether to (1) proceed and start a clinician-patient (Treatment) relationship (2) schedule another evaluation session before formalizing a Treatment relationship or (3) consider the first session a one-time evaluation and not form an ongoing Treatment relationship. If you and your clinician decide to start treatment, you will both discuss and document specific problems to be addressed, how therapy or treatment will work, agreed upon goals, treatment alternatives, possible treatment outcomes, anticipated difficulties (if any). You have the right to voice any disagreement, distress or concerns about the treatment plan, and request modifications. It is not uncommon to have some negative feelings or responses to treatment, especially in psychotherapy where symptoms sometimes get worse before improving. It's encouraged to discuss any concerns or negative feelings with your clinician. Your clinician is not required to start a Treatment relationship with you, and will discuss this case with you and offer treatment alternatives as applicable. Either you, or your clinician, can discuss stopping the Treatment relationship at any time, after which you will receive a letter documenting further instructions and that Treatment has ended.

APPOINTMENTS: Time is specifically reserved for you by your agreement. To cancel or change an appointment, you must call by the end of one 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 prior business day notice, or missed appointments will result in you being charged a fee, which is currently $125, and subject to change.** Two (2) or more consecutive late cancellations or missed appointments, or excessive appointment changes may result in termination of Treatment. If several months pass without phone contact or an appointment, the 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 or online. 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 before you. Our goal is to minimize wait times.

(**Your initials indicate that you specifically understand cancellation requirements. Initial Here: _____**

STATEMENT OF FINANCIAL ARRANGEMENTS FOR PROFESSIONAL SERVICES. Please read this financial policy carefully. If your clinician participates ("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 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 follow-up visits, you may pay any copayment or coinsurance, & we will bill your insurance for the balance. It is understood, 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. You are required to inform us immediately of any insurance changes, and promptly respond to insurance information requests. If payments are denied because you do not inform us in time to be paid by your new insurance, or you fail to respond to insurance communications, then you will be responsible for payment, even if your clinician is in-network.

Some items are non-covered by your insurance and are listed here. Your signature below indicates you are advised and you agree in advance to be solely responsible for charges for these non-covered services, including: 1. Completion of disability forms, special letters, or other documents (not routine insurance billing). 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, or electronic only. 3. Extended or non-emergency phone calls (if not covered by insurance). You will be notified during a call if charges apply. 4. Prescription refills outside of office visits are $10 each. (NOTE: there is never a fee for prescriptions during an office visit). 5. Appointment outside of normal business hours (8:30 to 4:30 Monday- Friday), such as evenings or weekends, will have an additional charge to your insurance company. If your insurance pays, you may owe a copay or deductable on this amount. If your in-network insurance declines the after-hours fee, then you are NOT responsible for it.

FINANCE CHARGES: it is clearly understand that any account balance not paid within 30 days after the first statement, accrues monthly interest at 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. The ePAY on our website allows payment plans for up to 18 months with no finance charges.

EMERGENCY CONTACT PROCEDURES: your clinician is available by emergency voicemail at 949-768-2988, by following the voicemail prompts, for urgent situations which cannot wait until the next appointment. Leaving an emergency voicemail will automatically page your clinician to return your call. You MUST accept a call from a blocked number for the clinician to call you. It is your responsibility to call your clinician 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. Non-emergency calls received during business hours are usually returned the next business day. If your clinician is unavailable, a covering clinician will return emergency calls. For serious emergencies, please call 911 or proceed to the nearest emergency room.

PATIENT RESPONSIBILITY & PRESCRIPTION REFILL PROCEDURES: You agree to abstain from excessive alcohol use and use of any outside drugs including marijuana during treatment here. Female patients of child-bearing age must inform the treating clinician of any plans to become pregnant or suspected pregnancy. You also agree to proper behavior in the office and during telehealth visits. The office has a zero-tolerance policy for excessive hostility, foul language, uncontrolled anger, violence or threats of any kind.

To qualify for prescription refills, you must have an upcoming appointment on the schedule first, and your clinician may require you to be seen quickly before issuing a new prescription. Routine prescription refills are NOT considered emergencies, and can take up to 72 hours to complete, so please allow adequate time for refills. Prescription refills are done by pharmacy fax requests only, so please call your pharmacy to send a fax. If your Treatment relationship is stopped, your clinician at his/her sole discretion, may issue one final prescription to allow you time to see another provider. Your provider may require you to schedule a follow-up appointment instead of authorizing a prescription by phone.

I have completely read, fully understand and agree to the above terms and information, and I consent to treatment at Advanced TMS Center.

Patient Name (printed):_____ Patient Signature:_____

Legal Guardian name:_____ Guardian relationship:_____

Legal guardian signature:_____

Clinician by signing below, indicates that he/she has discussed these issues and answered any patient questions regarding the above information.

Clinician name (printed) :_____

Clinician Signature:_____

ADVANCED TMS CENTER 333 Corporate Dr #260, Ladera Ranch, CA 92694
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information (PHI) in accordance with the Privacy Rule of the Health Insurance Portability & Accountability Act of 1966 (HIPAA). Completing this document authorizes the disclosure and/or use of your PHI. Failure to provide all information requested may invalidate this authorization.

Patient Name:_____ Date:_____ Date of Birth: _____

I hereby authorize this person or company:

(person/organization having your records)	(person/organization having your records)
(address of person having your records)	(address of person having your records)
(phone # of person having your records)	(phone # of person having your records)

To release to:

(person/organization having your records)	(person/organization having your records)
(address of person to release records to)	(address of person to release records to)
(phone #) (fax # if available)	(phone #) (fax # if available)

a. The following information is to be released:

____ ALL or if requested, list Specific Date(s) of service: _____ to _____
____ Discharge summary – Date(s) of service: _____ to _____ or _____ All
____ Lab Tests – Date(s) of service: _____ to _____ or _____ All
____ Radiology reports – Date(s) of service: _____ to _____ or _____ All
____ Entire Record – all Date(s) of service
____ Genetic information/testing (specify): _____
____ Other (specify needed information and date[s] of service if known): _____
_____ I

b. I specifically authorize the release of the following information (check as appropriate. Note: the first three fields MUST be CHECKED if records are to be **released from** the Advanced TMS center to a specified recipient):

___Mental health treatment information (Excluding psychotherapy notes, which require a separate release)
___HIV and/or sexually transmitted disease test results
___Alcohol/drug treatment information
___Genetic information/testing (specify): _____Patient's Initials (or check marks if digitally signed):

_____ **I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). Outgoing records from Advanced TMS Center will include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.**

_____This document is for inbound records and reciprocal exchange of records. Records can be sent from Advanced TMS Center to other parties only when accompanied by a separate, specific Records Request Form for patients.
_____I understand my treatment or payment for treatment cannot be conditioned on signing of this authorization.
_____ This authorization is valid for two years from the date signed, unless another date is indicated here: _____
_____ I authorize the parties listed above to reciprocally share (back and forth) my PHI with each other, either verbally or electronically, regardless of which party is marked "to" or "from."
_____ A facsimile, copy, or photocopy of this authorization shall authorize the release of records requested herein.

PURPOSE: The purpose of the release of this information is:

___Insurance or other third-party reimbursement
___Continuity of medical care with another provider
___Pending legal action
___At the request of the patient
___Other: (Specify) _____

RESTRICTIONS:

According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that in some cases the treating clinician may need to approve the release. In some cases a summary oftreatment may be substituted for actual records, in which case the reasons therefore will be documented

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Advanced TMS Center, all clinicians, and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS:

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits including insurance payment.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of, and if I request this, a copy of this release form made out to myself and signed by me is needed. I understand a fee may apply for copies of my medical records.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address 333 Corporate Drive #260, Ladera Ranch, CA 92694.

My revocation will take effect upon receipt, except to the extent that we or others have already acted in reliance upon this authorization.

I have a right to receive a copy of this authorization on request.

I am aware that information disclosed pursuant to this authorization could be re-disclosed by the recipient.

Patient SIGNATURE: _____

Patient Name (printed): _____

Note: If patient is under 18 or has a Guardian or Conservator, a parent, Guardian or Conservator must also sign:

Legal Guardian or other Signature:_____

Legal Guardian/other Name (printed):_____

Relation to Patient _____