NuMe
TMS CLINICS

Audio Video Consent:

Our office contains audio-video recording devices in the Deep TMS treatment rooms. The recordings are not part of your medical records and are not generally kept permanently. You have the right to refuse to be recorded during treatment sessions, however you must request this in writing when scheduling an appointment in order for arrangements to be made. Unless you request it in writing, the clinicians may record any patient Deep TMS encounter in the treatment room. At the beginning of a Deep TMS treatment, you can request that the operator unplug the recorder but this will prevent the physician from watching the session should problems arise.

Patient Initials: _____

Grievances:

If you have a grievance with your provider, another member of the office staff or a complaint about one of our policies, we ask that you first communicate this to a member of the staff so they may attempt to resolve the issue. If you air your grievances online on a review site or another public forum, you agree that you are forfeiting your rights to patient confidentiality. Online forums can legally be obligated to release the identities of anonymous posters. Additionally, you give our office full permission to respond in detail in the same forum you brought the subject up in.

If a frivolous or dishonest complaint is made outside of our office channels (i.e. to a State Medical Board), you will be liable for all of the costs as well as the forensic hourly rate (double the normal rate) for the work spent addressing your allegations.

Patient Initials: _____

Arbitration Agreement:

Arbitration means you waive your right to a jury trial. Due to the high costs of medical malpractice insurance and litigation, this office requires every patient sign an arbitration agreement. This means that all potential disputes are resolved through arbitration and not in court. This is mandatory for anyone who chooses to be a patient at NuMe TMS Clinics. In the event of a dispute of any nature arising between the parties or their heirs at any time, as a result of clinicians providing medical services, advice, treatment, informed consent, prescriptions, tests, and procedures whether in person or by phone, writing, internet, in the home, office, hospital, or otherwise, including a dispute or an injury from our staff, employees, or our property, the parties hereto agree to submit the dispute to binding arbitration under the rules of the Independent American Arbitration Association or any other arbitration company of the physicians choosing. An award rendered by the arbitrator(s) shall be final and binding upon the parties and judgment on such award may be entered by either party in the highest court having jurisdiction. Each party hereto specifically waives his/her right to bring the dispute before a court of law and stipulates that this agreement shall be a complete defense to any action instituted in any local, state, or federal court or before any administrative tribunal.

Patient Initials: _____

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Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signed: _____ Date: _____

Printed Name: _____

Relationship to Patient (if signed by someone other than patient): _____

Release of Information:

☐ I authorize the release of information, including but not limited to, appointment dates/times, diagnosis, prognosis, treatment, and billing. This information may be released to:

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ My information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date: _____

Printed Name: _____

Permission to Leave Messages (Optional):

By signing below, I give the staff at NuMe TMS Clinics, PLLC permission to leave detailed appointment information on my voicemail at the phone number(s) that I have provided to their office. I understand that I have the right to revoke this authorization at any time.

Signed: _____ Date: _____

Printed Name: _____

Deep TMS Consent:

Consent:

I understand that Deep TMS is not effective for all patients with major depression. I will report any signs or symptoms of worsening depression immediately to my doctor.

I have read the information contained in this consent and in the Patient Manual supplied by NuMe TMS Clinics, PLLC for Brainsway Deep TMS. I understand that there are alternative treatments for Major Depressive Disorder. I also understand the risks and benefits of Deep TMS as contained in the Patient Manual and included in the consent. I have been provided a copy of this consent and the Patient Manual. I understand that I may discontinue Deep TMS treatments at any time and for any reason.

All of my questions regarding Deep TMS treatments have been answered and I wish to proceed with the recommended treatment plan.

I give permission for NuMe TMS Clinics, PLLC to administer Deep TMS to me.

Signed: _____ Date: _____

Printed Name: _____ DOB: _____

Witness: _____ Date: _____

Printed Name: _____

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Financial Agreement:

Patient Information:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Marital Status: _____ Sex: M / F

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance Information:

Primary Ins: _____ Member ID #: _____

Group #: _____ Phone: _____ Policy Holder: _____

SS#: _____ DOB: _____ Relation to patient: _____

Secondary Ins: _____ Member ID #: _____

Group #: _____ Phone: _____ Policy Holder: _____

SS#: _____ DOB: _____ Relation to patient: _____

Office Policy: Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. As a courtesy, we bill most insurance companies. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days from the date of service, the claim will be payable by you. If your insurance requires an authorization or referral for your visit, you are responsible to obtain/maintain the authorization or referral. Our office hours are Monday – Friday 8am to 4pm, we are closed most holidays. For emergencies, please call 911 or go to your local emergency room. Please note our office does not allow and is not responsible for unattended children in our lobby. If you need to cancel or change your appointment, please do so 24 hours in advance.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to NuMe TMS Clinics, PLLC for performed services. I authorize the holder of medical information about me or any information needed to determine these benefits to be released to the insurance company above.

Signed: _____ Date: _____

Printed Name: _____

Relationship to Patient (if signed by someone other than patient): _____

Witness: _____ Date: _____

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Patient Health Data Form:

Name: _____ DOB: _____

Age: _____ Weight: _____ Height: _____ Sex: M / F

Primary Care Physician: _____

Completed by (if other than patient): _____ Relationship: _____

Prior psychiatric/psychological treatment: **Dates:**

Psychiatric Hospitalization(s): _____

Psychiatrist(s): _____

Counselor/Therapist(s): _____

Please list current and past anti-depressant medications:

Medication Name:	Dosage:	Side Effects:	Dates:

Family History:

☐ Nervous or mental illness If yes, who? _____

☐ Alcohol or drug use If yes, who? _____

Drug Use: (if yes, please provide details)

☐ Smoke:	☐ PCP:
☐ Marijuana:	☐ Stimulants:
☐ Cocaine:	☐ Caffeine:
☐ LSD:	☐ Alcohol:

Health History:

☐ History of physical abuse	☐ High blood pressure	☐ Head injury
☐ History of sexual abuse	☐ Shortness of breath	☐ Fainting
☐ History of psychological abuse	☐ Chest pain	☐ Motor difficulties
☐ Recent loss/death in family	☐ Possible/verified pregnancy	☐ Recurring headaches
☐ Divorce	☐ Stroke	☐ Vertigo/dizziness
☐ Heart disease	☐ Seizures	☐ Cancer
☐ Lung disease	☐ Loss of consciousness	☐ Current nausea/vomiting

Current Medications: _____

List known allergies: _____

List serious medication side effects: _____

Further information that would help your doctor provide safe and quality medical care: _____

_____

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Metal Screening Form:

Name: _____ DOB: _____

This section is to be filled out by the PATIENT or patient representative.

Please indicate if you have any of the following:

☐ Aneurysm clips or coils	☐ Wearable cardioverter defibrillator
☐ Cardiac pacemaker or wires	☐ Implanted insulin pump
☐ Internal cardioverter defibrillator (ICD)	☐ Programmable shunt or valve
☐ Carotid or cerebral stents	☐ Hearing aid
☐ Deep brain stimulator	☐ Cervical fixation device
☐ Metallic devices implanted in your head	☐ Surgical clips, staples, or sutures
☐ Dental implants	☐ VeriChip micro transponder
☐ Cochlear implant/ear implant	☐ Wearable monitor (e.g., heart monitor)
☐ CSF (cerebrospinal fluid) shunt	☐ Bone growth stimulator
☐ Eye implants	☐ Wearable infusion pump
☐ Cardiac stents, filters, or metallic valves	☐ Radioactive seeds
☐ Tattoo	☐ Portable glucose monitor
☐ Vagus Nerve Stimulator (VNS)	☐ Tracheostomy
☐ Blood vessel coil	☐ Medication patch/nicotine patch
☐ Shrapnel, bullets, pellets, BBs, or other metal fragments	☐ Other implanted metal or device:

Have you ever been a machinist, welder, or metal worker? YES / NO

Have you ever had a facial injury from metal and/or metal removed from your eyes? YES / NO

Have you ever had complications from an MRI? YES / NO

Signed: _____ Date: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Name: _____ DOB: _____

I hereby authorize (name of your provider): _____ and his/her employees to use and or disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my healthcare will not be affected if I do not sign this form.

☐ Obtain information from: AND/OR ☐ Disclose information to:

Name: _____ Phone #: _____

Address: _____

CATEGORY AND TIME PERIOD OF PHI:

Please initial the category of PHI you wish to release:

☐ Entire Medical Record
☐ Initial Evaluation
☐ Progress Notes
☐ Claims/Billing Information
☐ Therapy Notes
☐ Lab Results

☐ Other _____

TIME PERIOD OF HEALTHCARE TREATMENT RECORDS YOU WISH TO BE INCLUDED:

☐ Anytime
☐ Healthcare provided between dates: _____

LIMIT OF PHI:

I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/dur abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI I would have indicated below by initialing the appropriate category of PHI I DO NOT wish to be released.

_____ HIV/AIDS test results or diagnosis _____ Alcohol/Drug abuse _____ Other: _____

PURPOSE OF PHI:

☐ Continuity of Care
☐ Family Involvement
☐ Referral
☐ Other: _____

I understand that this authorization will expire on the following date: _____. If no specific date is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not effect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 413 N Allumbaugh St, Suite 102, Boise, ID 83704

Signed: _____ Date: _____

Relationship to Patient (if signed by someone other than patient): _____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information NOT sufficient for this purpose.