New Patient Information

DATE:_____

NAME:_____

ADDRESS:_____
_____
_____

SSN: _____
Date of Birth:_____

TELEPHONE:_____

EMAIL:_____

EMERGENCY CONTACT:_____
Phone:_____

Email Address_____

Insurance: _____ **ID#** _____

Primary Care Physician_____
Phone:_____ **From** _____ **To** _____

Psychiatrist:_____
Phone:_____ **From** _____ **To** _____

Therapist:_____
Phone:_____ **From** _____ **To** _____

General Information

Please describe the problems/needs that you would like help for:

Previous medical and/or emotional treatment you have received (include dates, hospitalizations, and surgeries):

Date on Onset of current episode: _____

Personal habits (indicate frequency and quantity per daily use):

Alcohol _____
Tobacco _____
Recreational Drugs _____
Caffeine _____

Do you have any medication allergies?

Yes
No
(If yes, please specify on the space provided below)

Family Psychiatric History (if applicable, indicate family member):

(a) Mental or emotional problems:
(b) Finances:
(c) Health (include allergies):

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

I _____ authorize to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	O R	I authorize _____ to obtain information from. _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

☐ Immunization history ☐ Administered by VA only. ☐ Include records submitted to VA. ☐ All medical records related to a specific illness or injury.

_____

Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology) ☐ Specific information (Select one or more, as applicable)

☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results
☐ Psychiatric/Psychology ☐ Other

_____

(Please describe.)

Notes

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR:

☐ This request only.
☐ One year from the date of this authorization **OR**, _____ (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any future treatment of the type described above until:_____

Insert Date

I understand that:

My right to healthcare treatment is not conditioned on this authorization.

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

  If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

  There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative_____Date _____

Relationship to Patient (if requester is not the patient)_____

PATIENT ARBITRATION AGREEMENT

The contract below is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in a court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement, you are changing the place where your claim will be presented.

You may still call witnesses and present evidence. Each part selects an arbitrator (party arbitrators), who then selects a third neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both the patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide medical care in such a way as to avoid such disputes. Therefore, if you have any questions about your care, please ask me.

By signing this agreement, the patient agrees with the provider that any dispute between you and Anew Era TMS and any dispute relating to medical services rendered for any condition, including any services prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgement in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective, and the remainder of the agreement shall remain effective. This agreement shall be governed and interpreted under the Federal Arbitration Act, 9 U.S.C Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician, including any spouse or children of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “Patient” herein shall mean both the mother and the mother’s expected child or children. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services:

Patient/Responsible Party Initials _____

The patient understands that the result of this arbitration agreement is that claims, including malpractices claims, he/she may have against the physician, cannot be brought as a lawsuit before a judge or jury, and agrees that all such claims will be resolved as described in this section.

Patient Name _____

Patient Signature _____ Date: _____

CONSENT FOR EMERGENT REPORT/SERVICES

I hereby give my consent for any diagnostic or therapeutic services, including Anew Era TMS, LLC diagnostic evaluation, examination, consulting, psychotherapy and other therapies as appropriate.

I understand that communication between my mental health professional* and I is confidential and privileged to the full extent of the applicable laws. Under these laws, the mental health professional* may disclose information about me to the staff of Anew Era TMS, LLC in the provision of therapy or appropriate referrals, and not otherwise without my written permission.

I further understand that certain circumstances are exceptions to the laws of confidentiality, under which a mental health professional* is legally required to report.
These include:

1. Intent to harm myself (suicide)
2. Intent to harm another person
3. Child abuse, physical and/*or* sexual
4. Abuse of an elder or dependent adult
5. Domestic violence

If a mental health professional* reasonably believes that one of the exceptions apply, he or she will make every effort to resolve the issue by discussing it with me before reporting to the proper agency.

I understand that in group therapy, there is a risk of disclosure of my confidential information by other group members and I will not hold the mental health professional liable for any breach of confidentiality by other group members.

Signanature_____Date_____

If not the patient, please print your name and relationship to patient.

Name_____

Relationship _____

*The term "mental health professional" includes any physician. therapist. counselor. or nurse that I may come in contact with in treatment at Anew Era TMS offices.

HIPAA NOTICE OF PRIVACY PRACTICES

A federal law known as the “HIPAA Privacy Rule” requires that we tell you how we use and give out personal health information about you to others. This summary will tell you what our Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

We may use and share personal health information that is protected (PHI) to you or your personal representative. We may use and share this information:

For healthcare treatment that doctors, nurses and other clinicians give you.

For certain business activities called “health care operations” and

For payment

Some examples of how we may use and share PHI about with without your written permissions including sharing information:

To report abuse, neglect, or domestic violence

To prevent a serious threat to you or other’s health or safety

To prevent public health problems

To agencies that audit, investigate and inspect health programs for the public’s health

For lawsuits and other legal proceedings

For research

To the Government for specialized purposes, such as military or national security; and

For worker’s compensation

YOUR RIGHTS

You have the following rights as described in our Notice:

The right to ask us if we will put more limits on the way we use and share PHI about you

The right to share confidential communications from us

The right to see and get a copy of PHI about you

The right to ask us for a report that describes how and with whom we chare PHI about you

If you have any questions regarding your rights or privacy – Please inquire with our office or reference https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

Eagan Medical Group, INC dba Anew Era TMS, LLC

I hereby acknowledge that I have read a copy of this HIPAA NOTICE OR PRIVACY PRACTICES. I further acknowledge that I may obtain a copy if requested.

PATIENT SIGNATURE _____ DATE: _____

FOR PATIENTS UNDER THE AGE OF 18:

RESPONSIBLE PARTY (PRINT) _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____ DATE: _____

Financial Policy (if we are filing with insurance):

In order to accommodate the needs and requests of our patients, we have enrolled in many managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Even within the same insurance company, the plans differ from policy to policy.

In the event that services are provided and your coverage is not in effect on that day, your deductible has not been met, or you have not requested authorization prior to service, charges will then become you responsibility. Payments are due at the time of service.

With you cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your mental health needs.

I have read and understand the financial policy stated above and agree to accept responsibility as described.

Signature: _____

Date: _____

Self Pay Patients:

I agree to pay the full billed amount for each session. I understand that these charges can be billed to my insurance company on my behalf at my request, but that all charges are solely my responsibility.

Signature: _____

Date: _____

TMS Contraindications Check List

Yes ___ No ___ Intracranial metallic or magnetic pieces transient magnetic field can displace or heat objects

Yes ___ No ___ Pacemakers and other implanted medical devices induced pulse may disturb electronic circuitry

Yes ___ No ___ History of seizures or epilepsy including history in a first degree relative

Yes ___ No ___ Medications (e.g. TCAs, neuroleptic agents) reduction in seizure threshold

Yes ___ No ___ Pregnant

Yes ___ No ___ History of serious head trauma

Yes ___ No ___ History of substance abuse

Yes ___ No ___ Stroke

Yes ___ No ___ Bullet fragments

Yes ___ No ___ Brain surgery

Yes ___ No ___ Other medical/neurologic conditions either associated with epilepsy or in whom a seizure would be particularly hazardous

Initial here _____

This is a providing disclaimer for non-medical services, this is a non-medical evaluation to determine your appropriateness and eligibility for TMS treatment. This is not an agreement to provide psychiatrist services. This is a TMS consultation only.

Please check the appropriate box:

◯ I have a primary prescribing physician

If checked yes, please circle what type of provider.

PCP Psychiatrist Psychiatric NP OB/GYN Other_____

Name_____Practice_____

Address_____City_____St_____Zip_____

Phone #_____

◯ I do not have a prescribing physician

◯ I wish to be referred to a prescribing physician

In the event that you are deemed an appropriate candidate and you are approved to move forward with TMS treatment, you are temporarily under the care of our prescribing physician. Our psychiatrist may evaluate your medication and may suggest changes to your current medication maintenance, or evaluate you for medication appropriateness.

If you are not currently under the care of a primary prescribing physician and are evaluated for medications, our doctors may evaluate you or potentially prescribe a psychiatric medication for you. Once you have been discharged from treatment, you will be given a 30-day supply of medication and expected to transition back to your primary care physician, a new prescriber, or a new psychiatrist. Physician referrals will be given to you upon request for your convenience.

Do not discontinue any psychiatric medications without the supervision of a medical doctor.
We strive to provide excellent care for you. If you have any feedback or comments to improve our services, please let any of our staff know.

Prior Treatment History

We are happy to provide the consultation for you and to discuss available treatment options for your condition.

In order for us to have the most productive consultation and recommendations, we would very much welcome any and all information you can provide about your condition at the time of the consultation if at all possible. You might not remember all the details however sometimes consulting others who are familiar with your condition (family members or friends), your prior records as well as pharmacy refill records can help complete the list.

Please take a few minutes to complete the following prior treatment questionnaire. Check the medications you have ***tried***, and in the comments include dosage and approximate length of treatment and outcome.

Insurance coverage for TMS treatment requires past history of medication attempts to treat depressive symptoms. Please list *all* medications and/or therapies that you have tried.

A. MEDICATION TREATMENT:

Medication Class & Examples	Highest Dosage	Side Effects, Reason for discontinuation, ect...
1. SSRIs (Selective Serotonin		
Reuptake Inhibitors):		
Prozac (Fluoxetine)		
Zoloft (Sertraline)		
Paxil (Paroxetine)		
Celexa (Citalopram)		
Lexapro (Escitalopram)		
Luvox (Fluvoxamine)		
Other:		
2. SNRIs (Selective Serotonin		
& Norepinephrine Reuptake inhibitors)*:*		
Effexor (Venlafaxine)		
Pristiq (Desvenlafaxine)		
Cymbalta (Duloxetine)		
Trintellix (Vortioxetine)		
Other:		
3. Atypical Antidepressants:		
Wellbutrin (Bupropion)		
Aplenzin (Bupropion Hydrobromide)		
Remeron (Mirtazapine)		
Serzone (Nefazodone)		
Trazadone (Desyrel)		
Viibryd (Vilaodone)		
Brintellix		
Fetzima		
Other:		
4. Tricyclic Antidepressants:		
Elavil (Amitriptyline)		
Tofranil (Imipramine)		
Pamelor (Nortriptyline)		
Norpramin (Desipramine)		
Aventyl (Nortriptyline)		
Asendine (Amoxapine)		
Ludiomil (Maprotiline)		
Other		

S. Monoamine Oxidase		
Inhibitors (MAOIs):		
Nardil (Phenelzine Sulfate)		
Emsam patches		
Other:		
6. Neuro-antipsychotic (SCA):		
Abilify (Aripiprazole)		
Seroquel (Quetiapine)		
Risperdal (Risperidone)		
Zyprexa (Olanzapine)		
Geodon (Ziprasidone)		
Latuda		
Invega		
Rexulti (Brexpiprazole)		
Other		
7. Mood Stabilizers:		
Lithium		
Depakote		
Tegretol		
Trileptal		
Lamictal (Lamotrigine)		
Other:		
8. Augmentation		
Thyroid supplements		
(Synthroid, Levoxyl, Cytomel,		
Armour thyroid, etc.)		
_Psychostimulants		
(Ritalin, Adderall, Dexedrine,		
Vyvanse,Provigil, Nuvigil)		
Buspar (Buspirone)		
Deplin (L-Methylfolate),		
Other:		

B. PSYCHOTHERAPY:
___ Supportive
___ Cognitive Behavioral (CBT)
___ DBT
___EMDR

Other (please specify):
C. Electroconvulsive Therapy (ECT, Shock therapy):
D. Prior Transcranial Magnetic Stimulation (TMS):
E. Psychiatric admissions or Partial Hospital Treatment:

CREDIT CARD ON FILE CANCELLATION POLICY

At Anew Era TMS, LLC., we require keeping your credit or debit card on file in order to secure your appointment with our medical professionals.

We require a 24 hour cancellation notification otherwise a no-show, non-reimbursable fee of $75.00 will be charged to your credit card. Your credit card information is kept confidential and secure and payments to your card are processed.

I authorize Anew Era TMS., to charge the portion of my bill and/or no show appointments that are my financial responsibility to the following credit or debit card:

Credit Card Number: _____ ☐ **Amex** ☐ **Visa** ☐ **Mastercard**___

Expiration Date _____ / _____ / _____ **CVC** _____
Cardholder Name: _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Anew Era TMS, LLC. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

In the event that your insurance company pays you directly for TMS services rendered and billed on your behalf, you are responsible to provide such payment(s) to Anew Era TMS, LLC immediately, otherwise your credit card will be charged for the amount paid to you by your insurance company.

This authorization relates to all payments not covered by my insurance company for services provided to me by Anew Era TMS, LLC..

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Anew Era TMS LLC, in writing and the account must be in good standing.

Patient Name (Print): _____ Date: _____ / _____ / ____

Patient Signature: _____

Name:_____ Date::_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Name:_____ Date::_____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myselF
- 2 I am disgusted with myself.
- 3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.
1 I cry more now than I used to
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score_____Levels of Depression

1-10_____These ups and downs are considered normal
11-16_____ Mild mood disturbance
17-20_____Borderline clinical depression
21-30_____Moderate depression
31-40_____Severe depression
over 40_____Extreme depression

Name:_____ Date::_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____