PATIENT INFORMATION

NAME: _____
(LAST) (FIRST) (Middle Initial) Preferred Name

DATE OF BIRTH (mm/dd/yy) _____

GENDER (assigned at birth): Male _____ Female _____

SOCIIAL SECURITY NUMBER _____

MAILING ADDREESS: Street _____ City _____ Zip Code _____

E mail: _____

PHONE NUMBER: (Home) _____ (Cell) _____

MARITAL STATUS: ☐ Married, ☐ Single, ☐ Divorced, ☐ Widowed, ☐ Other _____

REFERRING SOURCE: _____

EMERGENCY CONTACT: _____ Relationship _____

INSURANCE INFORMATION/ RESPONSIBLE PARTY INFORMATION

PRIMARY INSURNACE: _____

INSURANCE SUBSCRIBER: _____ SUBSCRIBER'S DOB: _____ Relationship to Patient: _____

Policy #/ Member ID: _____ Group ID #: _____

SECONDARY INSURNACE: _____

Policy #/ Member ID: _____ Group ID #: _____

HEATHCARE PROVIDERS

PRIMARY CARE PROVIDER: _____ PHONE: _____ FAX: _____

PSYCHIATRIST: _____ PHONE: _____ FAX: _____

THERAPIST: _____PHONE: _____ FAX: _____

I authorize release of the results of my treatment upon conclusion to:

☐ PRIMARY CARE PHYSICIAN ☐ PSYCHIATRIST ☐ THERAPIST ☐ OTHER _____

PATIENT SIGNATURE: _____DATE: _____

HEALTH HISTORY QUESTIONAIRE

Before receiving TMS treatment we need to make sure it is safe for you to do so. We will need information about possible factors that could enhance your risk to unintentional adverse effects Please fill out the following questionnaire:

1. Do you have a history of the following conditions in the past or recently within the last 12 months

o Bipolar disorder ☐
o Schizophrenia or schizoaffective disorder ☐
o Substance Abuse or dependence ☐
o PTSD ☐
o Eating disorder ☐
o Head injuries/ TBI ☐
o Seizures or Epilepsy ☐
o Cerebrovascular accident or Stokes ☐
o Dementia ☐
o Increase Intracranial pressure/Hydrocephalus ☐
o Movement disorders ☐
o Other neurological conditions ☐

2. Have you been through any trials of psychotherapy in your lifetime?

CBT (Cognitive behavior therapy): ☐ Yes ☐ No Dates: _____ Provider name: _____

Biofeedback: ☐ Yes ☐ No Dates: _____ Provider name: _____

DBT (dialectical behavior therapy): ☐ Yes ☐ No Dates: _____ Provider name: _____

EMDR (Eye movement Desensitization and Reprocessing) ☐ Yes ☐ No Dates: _____ Provider name: _____

Trauma focused therapy: ☐ Yes ☐ No Dates: _____ Provider name: _____

PHP/IOP in hospital: ☐ Yes ☐ No Dates: _____ Provider name: _____

3. Do you have any of the following implants in your body?

Metal plates or screws: ☐ Yes ☐ No _____

Artificial heart valves: ☐ Yes ☐ No _____

Metallic splinters, Shrapnel, etc.: ☐ Yes ☐ No _____

Internal hearing Aids (cochlear implant): ☐ Yes ☐ No _____

Vascular clips/ Pacemaker: ☐ Yes ☐ No _____

4. Have you undergone an MRI for clinical purposes? ☐ Yes ☐ No

If yes did any problems occur during scanning ☐ Yes ☐ No, please explain _____

5. Please List All current and Previous Antidepressants You have taken

SSRI's (Fluoxetine, Paroxetine, Citalopram, Escitalopram, Sertraline, Fluvoxamine)

Dates tried: _____ Side Effects: _____

SNRI (Venlafaxine, Desvenlafaxine, Duloxetine, Fetzima)

Dates tried: _____ Side Effects: _____

Wellbutrin (Bupropion)

Dates tried: _____ Side Effects: _____

6. Have you received Prior TMS Therapy? ☐ Yes ☐ No

If yes, please specify Dates: _____

Experience with the procedure: _____

Side effects with the procedure: _____

7.In the past few years have you used any of the following substances:

SUBSTANCES USED	Age first started	Use Frequency	Years Used	Last use	Current use	Treatment
CANNABIS/Mj/WEED						
COCAINE						
AMPHETAMINES/METH Other Stimulants						
SEDATIVE /HYPNOTICS **Xanax, Valium, Ativan**						
HEROIN or OTHER OPIOIDS- Pain pills						
HALLUCINOGENS **LSD, PCP, Mushrooms Ecstasy, Nitrous Oxide**						
INHALANTS						
OTHER: specify						

Perfect Balance Psychiatric Services and TMS Center Patient Name: _____

Primary Care Physician (please print their name) _____

Current Medical Issues: _____

Do you have any of the following medical problems?

○ Hypertension/High Blood Pressure ☐	○ Constipation / Diarrhea/IBS ☐	○ Cancers/Malignancy ☐
○ Heart Disease/Chest Pains ☐	○ Asthma ☐	○ Migraine Headaches/other headaches ☐
○ CHF (heart failure) ☐	○ Chronic Lung Disease ☐	○ Seizures ☐
○ Diabetes/Borderline Blood sugars ☐	○ Anemia ☐	○ Head Injury ☐
○ Liver Disease ☐	○ Bleeding Tendency ☐	○ Stroke ☐
○ Stomach Ulcers ☐	○ High Cholesterol ☐	○ Thyroid Issues ☐
○ Dizziness/ Vertigo/ Balance ☐	○ Sexual Health issues ☐	○ Vision Problems ☐
○ Urinary Problems ☐	○ Arthritis / Joint issues ☐	○ Hearing Issues ☐
○ Other Medical Problems ☐: Please list		

Past Surgical History: _____

Menstrual History: _____

Pregnancies: _____

ALL PATIENTS/RESPONSIBLE PARTIES PLEASE READ AND SIGN BELOW

By signing below, I attest I have answered all questions truthfully and t the best of my knowledge

_____

Name of Patient

SIGNATURE _____ Date _____

9300 John Hickman Pkwy, Suite 101
Frisco TX 75035

TEL. # (972) 781-0100, FAX # (972) 781-0101

Patient Informed Consent for TMS Therapy

This consent form outlines the treatment that your provider has prescribed for you based on your psychiatric evaluation. It outlines the details of the procedure along with the potential risks versus the benefits.

I acknowledge that following information has been explained to me by my provider:

1. **TMS stands for "Transcranial Magnetic Stimulation". It is a noninvasive FDA cleared medical procedure for delivering magnetic stimulation to the brain for therapeutic benefits. The magnetic impulses generate a weak electric current in the brain that briefly activates the neural circuits at the stimulation site.**

2. **TMS Therapy is generally a safe and effective treatment for patients with depression who have not benefitted from antidepressant medications and are considered as treatment resistant cases.**

3. **There have been other conditions that have also been approved for TMS therapy like OCD and cigarette smoking that have received FDA clearance.**

4. **Using TMS for conditions other than treatment resistant MDD and OCD is considered off label currently. In the United States physicians are permitted to use FDA cleared medical devices for off label purposes if they believe it is safe and reasonably expect that such use will benefit their patients after providing them all the necessary information.**

5. **During a TMS treatment session, the doctor, or a member of their trained staff will place the magnetic coil gently against my scalp on the designated 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 responsible for causing the illness that I m being treated for currently.**

6. **To administer the treatment, the clinician will first position my head in the head support system. Next, the magnetic coil will be placed on the designated side of my head, and I will hear a clicking sound and feel a tapping sensation on my scalp. The doctor will then adjust the TMS Therapy system so that the device will give just enough energy to send electromagnetic pulses into the brain to generate a twitch in the hand or feet area. The amount of energy required to make that twitch is called the "motor threshold". Every Patient has a different motor threshold and the treatments are given at an energy level that is just above my individual motor threshold. My doctor will determine how often my motor threshold will be re-evaluated.**

7. **Once motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses" with a "rest" period of between each series. FDA has approved different protocols of TMS treatment session that range from 3 minutes to 37 mins. My doctor will discuss all those with me and recommend one that may suit to my needs better.**

8. **I was informed that most of those protocols are given 5 times a week for approximately 6- 7 weeks (up to 36 treatments). I will be evaluated by the doctor 5-7 times during this treatment course.**

9. **I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment.**

10. **During the treatment, I may experience a slight tapping sensation, facial twitching, or painful sensation at the treatment site while the magnetic coil is turned on. Most patients tolerate them quite well however some perceive some discomfort and pain and I understand that I should inform the doctor or the staff if this occurs. The doctor may then adjust the dose or make changes to where the coil is placed to help make the procedure more comfortable for me. I understand that both discomfort and pain get better over time and that I may take common over-the-counter pain medications such as acetaminophen if a headache occurs.**

11. **Due to the device making a sound or click with each pulse I understand I am permitted to wear ear plugs devices with a rating of 30 dB or higher of noise reduction during treatment to minimize the sound. There has been no reported case of permanent damage or hearing loss with the procedure.**

12. **Seizures have been reported with the use of all neurostimulation devices. However, the risk of seizures with TMS Therapy is extremely low (less than 0.3%)**

13. **There are no known adverse cognitive (thinking and memory) effects associated with TMS therapy. Also, no known long term adverse effects reported with the use of TMS. However, as this is a relatively newtreatment, there may be unforeseen risks in the long term that are currently unknown.**

14. **I was informed about the contra-indications of this treatment: The TMS Therapy System should not be used by anyone who has magnetic-sensitive metal in his or her head or within 12 inches of the magnetic 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 includes:**

    - **Aneurysm clips or coils**
    - **Stents in your neck or brain**
    - **Implanted Stimulators**
    - **Electrodes to monitor your brain activity**
    - **Ferromagnetic implants in your ears or eyes**
    - **Shrapnel or Bullet fragments**
    - **Facial tattoos with metallic or magnetic sensitive ink or any other metal devices or objects implanted in the head.**

15. **TMS Therapy is not effective for all patients with depression. Any signs or symptoms of worsening depression 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.**

16. **I understand that most patients who benefit from the TMS Therapy, experience results by the fourth or fifth week of treatment. Some patients may experience results in less time while others may take longer.**

17. **I understand that I may discontinue treatment at any time.**

I have read the information contained in this Medical Procedure Consent Form about TMS Therapy and its potential risks and benefits of treatment of my diagnosis _____. I have discussed it with Dr. Siddiki who has answered all my questions. I understand there are other treatment options for my depression available to me and this has also been discussed with me.

I therefore permit Dr. Siddiki and his staff to administer this treatment to me.

PATIENT SIGNATURE: _____DATE: _____
(Guardian's signature if patient is under 18)

PROVIDER SIGNATURE: _____DATE_____

PBPS - PATIENT HEALTH QUESTIONNAIRE FOR DEPRESSION (PHQ-9)

PATIENT NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "X" to indicate your answer)	Not at all 0	Several Days 1	Over Half the days 2	Nearly Every Day 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead, or of hurting yourself				

For Office Coding: _____ + _____ + _____

Total Score: _____

10. 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**

Perfect Balance Psychiatric Services and TMS Center Patient Name: _____

OFFICE / FINANCIAL POLICYAGREEMENT

Thank you for choosing Perfect Balance Psychiatric Services for your TMS medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this **Office / Financial Policy Agreement**. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Except as indicated below, payment is required at the time services are provided unless other arrangements have been made in advance. We accept cash, VISA, MasterCard, Discover and American Express credit cards. We also offer a third-party Medical Financing.

Office Hours (By Appointment Only)

- Monday through Thursday, 8:00 am to 5:00 pm
- Friday, 8:00 am to 3:00 pm
- Arrangements can be made for earlier or later TMS appointments

As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. For after-hours / weekend emergencies, please call 911 immediately.

Insurance

We participate in most managed care plans and will bill your insurance plan as may be necessary. PBPS uses a third- party service to do a Benefits Investigation. Although we are given the information which includes your co-pay, in-and-out of network benefits and deductible information, it is not our responsibility to manage your deductible. We will discuss with you the results of your Benefits Investigation prior to requesting an Authorization for TMS Therapy from your insurance company.

Proof Of Insurance And Secondary Insurance

All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information, you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service.

Insurance denials for termination of coverage will automatically be billed to you.

Co-Payments

All co-payments must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible and
non-covered services.

We offer options for payments:

(Please select one option for method of payment)

☐ Pay on Monday for the week of treatment sessions

☐ Pay one lump sum on the first day of treatment

Claim Submission

We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Insurance law requires your insurance company to provide timely payment. Please be aware that if there is a balance due on your claim, it is your responsibility to pay. We are not a party to your insurance contract. In the event that your insurance pays you directly, it is your responsibility to endorse the insurance check directly to our office and submit it to our office within three business days upon receipt.

Cash Pay

If we do not participate with your managed care plan, we require half of the total billable amount on the first day of treatment with the remainder due in weekly intervals on the Monday prior to the 4th, 5th and 6th week of treatment. Payment in full is required at the time of service, unless other arrangements are made in advance. Please note, any credit card payments will be subject to a 2.5% processing fee. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan.

Patent Initials _____

9300 John Hickman Pkwy, Suite 101
Frisco TX 75035

TEL. # (972) 781-0100, FAX # (972) 781-0101

Administrative Services, Charges and Patient Responsibilities

Due to the continued decline in reimbursements from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

- Missed appointments. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24-hour notice of cancellation to avoid a $50 cancellation fee. It is your responsibility to remember your appointment.
- Letters / Form completion. At the discretion of the Physician, letters and forms requiring medical review and Physician signature are subject to a $25 fee.
- Telephone Consultations / After-hours calls. Telephone consultations/after-hours calls for medical advice/treatment may be subject to a $30 fee that is billed directly to you.
- Requests for medical records. In accordance with state law, written requests must be signed for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on current State law and is dependent on the number of pages requested. Please take this into consideration when requesting copies of your medical records.

Out-Of-Network Care / Self Pay

Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. As a courtesy to our out-of-network patients, we will file your insurance claim if desired, and offer a 10% reduction from our usual fees. This benefit also applies to individuals without insurance.

Collection Fees and Service

It is never our intention to take our patients to collection. However, if it is necessary all laws will be enforced. Our Collections are administered through Premier Collection Service. They are allowed by law a commission rate based on the face amount of the assigned account, legal fees associated with the collection of the debt and are allowed all fees associated with the collection process. Once these accounts are assigned, we are no longer able to accept funds on their behalf or adjust terms. We will not turn anyone over to collection until we have exhausted our limits of acceptance. However, after 60 days without payment or other written and enforceable arrangements we will assign the note to collections.

I have read, understand, and agree to comply with the terms of your Office / Financial Policy.

NAME OF THE PATIENT: _____ DATE: _____

SIGNATURE OF THE PATIENT: _____

9300 John Hickman Pkwy, Suite 101
Frisco TX 75035

TEL. # (972) 781-0100, FAX # (972) 781-0101

Perfect Balance Psychiatric Services and TMS Center Patient Name: _____

HIPAA Consent

Your Information. Your Rights. Our Responsibility.

Your Rights

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on Page 1.
- You can file a complaint with the U.S. Department of Health and Human By sending a letter to 200 Independence Ave, S.W., Washington, D.C.20201, calling 1-877-696-8775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you.
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request,

in our office, and on our web site.

Effective Date of Notice: January 01, 22

This Notice of Privacy Practices applies to the following organizations.

Perfect Balance Psychiatric Services

I am a patient of Perfect Balance Psychiatric Services. I hereby acknowledge receipt of Perfect Balance Psychiatric Services' Notice of Privacy Practices.

NAME OF THE PATIENT: _____ DATE: _____

SIGNATURE OF THE PATIENT: _____

9300 John Hickman Pkwy, Suite 101
Frisco TX 75035

TEL. # (972) 781-0100, FAX # (972) 781-0101