Dear Client:

Thank you for choosing CNY TMS Psychiatry to be your TMS therapy provider. When you choose CNY TMS Psychiatry, you become a part of a vibrant and supportive team of professionals that exists for the sole purpose of preparing you for a life full of joy. You will never by "just another patient" – from the moment you walk through our door until long after you have completed the treatment phase.

Most insurance networks require a prior authorization before you begin therapy. So, to help protect each of our patients, **we ensure appropriate authorization** from your insurance is obtained before you begin treatment.

We've designed our **TMS Registration Form based on the information that will be required on your insurance's prior authorization form**. So, while we understand no one enjoys filling out these types of forms, **we ask that you please be as thorough as possible. If you can't remember specific dates, especially where previous medications are concerned, then just list an approximate date, including month and year**.

Most insurances will require the following:

- A diagnosis of depression (moderate to severe)
- A minimum of 2-4 antidepressant trials
- A history of psychotherapy (therapists, counselor, group therapy, outpatient therapy, extended visits with psychiatrist, or psychologists)
- PHQ-9 (Depression screening) score > or = 18

We thank you for taking the time to complete our TMS Registration and look forward to helping you to achieve long-term relief from your depression.

The CNY TMS Psychiatry Team

CNY TMS PSYCHIATRY

Client TMS Registration Form: (Adult)

BASIC INFORMATION: Date: _____

Client's Full Name:_____ Date of Birth:____/____/_____

Gender:_____Client's SSN:_____*Used for Insurance Reasons*

Mailing Street & Apt #:_____
I understand that by giving this address, statements and necessary forms will be mailed to the address provided.

City:_____State:_____Zip Code:_____

☐ Address has been verified by USPS.com/zip4 (Office Use)

Marital Status of Client: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Other _____

Contact Information:

Unless otherwise specified below, by providing phone numbers and emails you are giving permission for Hopefield Healthcare to leave voice mails and contact you via email. For additional information on email communication and privacy, please see our privacy policy.

Cell: (*Default*) _____Home:_____Work: _____

Optional: Do Not Leave Voice Mails on the following phone number(s): _____

Email Address:_____

Please use my email address for: ☐ TMS Clinic Communication ☐For Clinic Updates and Newsletters

Appointment Reminders:

Appointment reminders may be provided by our Electronic Medical Records (EMS) system. When your appointment is scheduled, we will confirm your appointment 2-5 days prior to your appointment time. By completing this section, you acknowledge that information through email/text/voicemail is not necessarily secure and we cannot guarantee that someone else will not access information regarding your appointment through these means.

☐ I prefer not to receive reminders.

To receive reminders, please check the box that applies:

☐Text or Call or Email ☐Email Only ☐Text Only ☐Call Only ☐Voicemail messages OK

Emergency Contact Information:

Name:_____Relationship to Client: _____

Phone Number:_____May we leave messages with this person: YES / NO (please circle)

Additional Contact Information:

Primary Care Doctor Name:_____Phone:_____

May we contact emergency contact provided regarding your care here? ☐ Yes ☐ No

Client Initials: _____

Client Registration Form: (Adult)

CNY TMS Psychiatry

Tele: 315-671-2140 /Fax: 315-673-2434

Financial Responsibility

Psychiatrist Name:_____Phone:_____

May we contact this person regarding your care here? ☐ Yes ☐ No

Therapist/Counselor Name:_____Phone:_____

May we contact this person regarding your care here? ☐ Yes ☐ No

Financial Responsibility Agreement:

CNY TMS Psychiatry reserves the right to charge for services rendered by any practitioner or provider employed by CNY TMS Psychiatry for all services rendered at our clinic(s). Please see the different sections below to indicate how payment will be collected and services will be billed. For any questions regarding this section, please be sure to ask one of our staff members.

Payments and Billing:

If you are 18 years of age or older, unless other signatures are provided, statements and financial responsibility will default to you.

Billing for services rendered is handled by our Billing Department. For privacy reasons, we do not fax or email statements unless specifically requested as a one-time courtesy. We expect co-pays and any co-insurance or deductibles to be paid at the time of service. To maintain a manageable client balance, the front office personnel will require payment of your co-insurance or deductible at the time of service. In some instances, clients may receive a statement due to insurance changes or other reasons.

Use of Insurance Plans:

By signing this form, you acknowledge that your insurance coverage, notification of any pre-authorization requirement, and terms of coverage are ultimately your responsibility. You acknowledge that insurance verification checks may not always reflect recent insurance claims, coverage of benefits, or other information. We make every attempt to verify your benefits and obtain pre-authorization and will communicate this to you. If it is not provided or different from what is communicated to us by your insurance provider, you understand that benefits checks and re-authorization is not a guarantee of payment. If pre-authorization is obtained, but your insurance provider rejects services, you may still be responsible for payment of services provided. We make every effort to obtain pre-authorization for services prior to the start of care and will communicate coverage with you. However, insurance changes occur during the course of treatment and it is your responsibility to notify our office of any changes.

If the **Insurance Holde**r is different than that of the Client/Patient receiving services, please provide the information here:

Full Name:_____Relationship to Client:_

_____Mailing Address & Apt #:_____

_____

City:_____State:_____Zip Code: _____

Date of Birth:_____/____/_____Gender:_____Phone Number: _____

Client Initials: _____

Client TMS Registration Form: (Adult)

Patient Initials: _____

Cancellation Policy
Past Due Balances
Consent to Treat
Acknowledgement of HIPAA

Cancellation Policy:

By signing this form, you acknowledge that by scheduling an appointment, we reserve time specifically for you. This time is set aside and prevents others from scheduling during your reservation. We request a minimum of 24 hours notice for any cancellations or reschedules. Because of the time set aside, if proper notice is not given for rescheduling or cancellation, a cancellation fee may be applied to your account.
Please be aware that failure to receive a reminder does not waive this cancellation fee. You are still responsible to remember your appointment dates and times.

Special Circumstances:

We make every effort possible to respect the wishes of our clients. However, CNY TMS Psychiatry and its affiliates is not responsible for maintaining financial arrangements made between separated or divorced parents or couples under any circumstances. If there is a financial agreement between such parties, we respect your privacy, and require that you manage those arrangements. For financial responsibility in these types of cases, the person whose signature is on file on the registration paperwork is deemed the party responsible for payment. We cannot acknowledge financial responsibility for a party who is not present to agree to the terms provided. (Statements can be provided to the responsible party, upon request, for proof of payment to other parties).

Past Due Balances:

By signing this document, you acknowledge that unpaid balances of 30 days past due status may be subject to being submitted for collections. If balances are not paid, we reserve the right to utilize collection agency services. Payments are expected at the time of service; however, if a balance is due, it is due within 30 days and may be accepted in person or by mail via cash, credit/debit card or health savings account card. In some situations, a payment plan may be arranged with CNY TMS Psychiatry.

Consent to Treatment:

By signing this document, you agree to the following statements:

I agree to participate in treatment and understand that a positive outcome cannot by guaranteed. I understand that positive outcomes are also based on my compliance with treatments but compliance does not guarantee a positive outcome.

CONFIDENTIALITY AND PRIVACY:

I have read and agreed to the Privacy Notice (HIPAA Statement) provided to me. I understand that I can obtain a printed copy from the staff, and can ask for clarification on any policies stated in it.

I** (print name)_____**have read and understood the above conditions of this document, and agree to them. I have asked any questions I am concerned with and understand the policies outlined above.

Patient Signature:_____Date:_____

Patient Printed Name: _____

Client TMS Registration Form: (Adult)

Insurance Information
Referred Entity
Medications

INSURANCE INFORMATION:

Name of Insurance:_____ID#:_____Group#:_____

Subscribers Name:_____Relationship to Patient: _____

Other Numbers of Insurance Card:_____Pre-Auth Phone#: _____

SECONDARY INSURANCE:

Name of Insurance:_____ID#:_____Group #: _____

Subscribers Name:_____Pre-Auth Phone#: _____

WHO REFERRED YOU FOR TMS THERAPY:

Name of provider who referred you: _____Psychiatrist / Therapist / Primary Doctor

Referral Source Phone #:_____May we contact: YES / NO

Do you have a diagnosis of Major Depression? YES / NO

CURRENT & PREVIOUS PSYCHIATRIC MEDICATIONS

Are you currently taking antidepressant medications: YES / NO
Please list your current and previous medications (*all current psychiatric medications - please answer to the best of your knowledge as information is required to obtain pre-authorization*):

Medication:	Dose:	Start Date:	Stop Date:	Reason for Discontinuation:

Are you currently taking or have you ever taken any medication for a seizure disorder: YES / NO If so, what medication:_____Start Date:_____Stop Date: _____

In the past 6 months, have you used alcohol(ETOH), illicit drugs, or abused benzodiazepines(Klonopin, Xanax, Ativan, etc.): YES / NO

If so, do you drink ETOH on a daily or weekly basis? YES / NO How much per:_____day
If you use illicit drugs, which ones: Marijuana / Opiates / Cocaine / Hallucinogens / Other_____
If you abuse benzodiazepines, which ones:_____How many mg per day: _____

Client TMS Registration Form: (Adult)

Pre-Authorization Criteria Acknowledgment

FOR TMS THERAPY INSURANCE AUTHORIZATION

For insurance pre-authorization insurance companies typically require the following, which is the minimum requirements in order for pre-authorization to be submitted:

- A confirmed diagnosis of Major Depressive Disorder or Treatment Resistant Depression, Obsessive Compulsive Disorder (OCD), or Bipolar Depression (BD)
- Prior trials of antidepressant medications with little or no benefit from symptoms OR medication discontinuation due to side effects (each insurance requires a specific number of antidepressant trials - for example, Medicare requires a minimum of two (2) antidepressants with little or no benefit or inability to continue medication due to side effects, other insurances requires a history of 3-4 antidepressants during the current episode.
- No history of seizures
- A history of psycho-therapy with little or no benefit (physician, therapist, counselor, outpatient mental health visits, etc.)
- No TMS Therapy contraindications
- Insurance requires a medical record documentation of all of the above, including other qualifying information, in order to obtain prior authorization for TMS Therapy services. Hopefield Healthcare will request your medical records from your health care providers in order to have this information on file for pre-authorization.

CNY TMS Psychiatry will submit a prior authorization to your insurance upon receipt of all required documentation from you and your current or previous health care providers.

Do you provide permission for CNY TMS Psychiatry to submit a prior authorization request to your insurance provider for TMS therapy (transcranial magnetic stimulation) services and/or for services to be provided to you by one of our physicians or healthcare providers. **Please circle: YES / NO**

I have read or have been made aware of the following:

- HIPPA Notice and Patient Privacy Acts
- TMS Therapy Contraindications
- TMS Therapy Hearing Protection Waiver
- Indications for and any side effects of TMS Therapy, including an explanation of TMS Therapy for the treatment of major depression or other diagnosis that I may be receiving TMS Therapy for.
- I have had all of my questions and/or concerns answered

I also understand that TMS therapy treatment sessions emit a loud ticking noise, similar to that of magnetic resonance imaging (MRI). There have been no reported history of hearing loss; however, earplugs are available and recommended for me to wear during each treatment session. I understand I may elect to decline wearing the ear plugs. I also agree to hold CNY TMS Psychiatry and each of its employees and physicians harmless from any liability related to any hearing problems during or after my treatment regardless of whether I elect to where or decline to wear earplugs (i.e., hard of hearing, hearing loss, or any other hearing-related problem.)

A parent signature is required for all patients under the age of 18. A guardian signature is required if patient has a guardian.

Patient Signature:_____ Date:_____

Print Name: _____

Parent or Guardian Printed Name:_____ Date:_____

Parent or Guardian Signature: _____

Client Initials: _____

Client TMS **Registration Form: (Adult)**

TMS Prior Authorization Information

Have you ever been diagnosed with Bipolar Disorder? ♡YES ♡NO OCD? ♡YES ♡NO
Schizophrenia? ♡YES ♡NO Substance Use Disorder? ♡YES ♡NO PTSD? ♡YES♡NO

Eating Disorder? ♡YES ♡NO Seizure Disorder? ♡YES ♡NO
Any other Neurological Disorder (dementia, Alzheimer's, stroke, autism, epilepsy)? ♡YES ♡NO

Onset of symptoms: ♡ loss of hope ♡ low self-esteem ♡ insomnia ♡ appetite changes ♡ sadness
♡ loss of interest ♡ decreased motivation ♡ irritability ♡ feeling down
♡ anxiousness ♡ sleeping too much ♡ lack of social activity

Currentsymptoms: ♡ increase in sadness ♡ sleeping too much ♡ increased irritability
♡ missedwork ♡ over-eating ♡ increased loss of appetite ♡ crying spells ♡ no motivation
♡ social isolation

Do you have current thoughts of: ♡ self harm ♡suicide ♡thoughts to harm someone else

Have you participated in outpatient therapy? ♡ Yes ♡ No
If so, where:_____When (estimate if needed):__mo___yr How long: _____

Do you have a therapist or counselor? YES NO If so, who? _____

Have you been hospitalize for depression in the past? Yes No Hospital: _____
If so, what was the approximate date:_____mo_____yr

Have you had any of the following in the past: ♡ TMS ♡ ECT ♡ Vagus Nerve Stimulator
Do you currently have a Vagus Nerve Stimulator? ♡ YES ♡ NO
If you've had TMS previously, please tell us where: _____
Did you receive a positive response: ♡ YES ♡ NO

Do you have any ferromagnetic or other magnetic-sensitive metals implanted in your head or within 30cm of your head? ♡ YES ♡ NO

Are you currently pregnant? ♡YES ♡NO If yes, are you nursing? ♡YES ♡NO

What types of psychotherapy have you tried in the past or are you currently in? ♡ N/A
Please check all previous types of psychotherapy:

♡ Therapist/Counselor ♡ Cognitive Behavioral Therapy (CBT) ♡ Client Centered Therapy (CCT/PCT)
♡ Existential Therapy ♡ Psychoanalytic or Psychodynamic Therapy (exploration of unconscious thoughts)
♡ Dialectical Behavioral Therapy (DBT) ♡ Interpersonal Psychotherapy (IPT) ♡ Mindfulness Therapy
♡ Group Therapy ♡Other Therapy: _____
♡ Extended visits with psychiatrist

At what age were you initially diagnosed with depression (estimate): Age: _____

I,_____attest that I have completed the above assessment and that the information provided is true and accurate to the best of my knowledge. I authorize CNY TMS Psychiatry to submit a pre- authorization request to my insurance based on the above information and request my medical records if necessary.

Patient Signature:_____Date:_____

Patient Printed Name: _____