PATIENT FACE SHEET	
PATIENT NAME:	
PATIENT DOB:	
PATIENT PHONE #:	
INSURANCE:	
MEMBER ID:	
GROUP NUMBER:	
PATIENT ADDRESS	
PRIOR AUTHORIZATION #: (for office use only)	
INS. CONTACT NAME/ DIRECT NUMBER:	
INITIAL DATE OF TREATMEANT:	
AUTH TIME FRAME/ # OF SESSIONS:	
AUTH TIME FRAME/ # OF SESSIONS:	
ADDITIONAL NOTES:	

Patient Consent for TMS Therapy

This is a patient consent for a medical procedure called TMS Therapy. This consent form outlines the treatment that Dr. Abbas has prescribed for you, the risks of this treatment, the potential benefits of this treatment, and alternative treatments that are available for you if you decide not to be treated with TMS Therapy.

Dr. Abbas and/or a member of his team has explained the following information to me:

1. TMS stands for "Transcranial Magnetic Stimulation". TMS Therapy is a medical procedure. A TMS treatment session is conducted using a device called the TMS Therapy System. This system provides electrical energy to a "treatment coil" or magnet that delivers a pulsed magnetic field. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines.

2. TMS Therapy is a safe and effective treatment for those patients with depression who have not benefitted from multiple antidepressant medications given at high enough dose and for a long enough period of time but did not improve.

3. During a TMS treatment session, Dr. Abbas or a member of the TMS Therapeutics staff will place a magnetic coil gently against the patient's scalp on the left front region of the patient's head.

4. To administer the treatment, Dr. Abbas or a member of TMS staff, will first position the magnetic coil on the left 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 machine so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right hand moves slightly in a twitching motion. The amount of energy required to make my hand twitch is called the "motor threshold". Treatments are given at an energy level that is just above my individual motor threshold.

5. Once a motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses" that last about 4 seconds, with a "rest" period of about 26 seconds between each series. Treatment is to the left of the front side of my head and will take about 40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. I will likely receive these treatments 5 times a week for 4 to 6 weeks (20 to 30 treatments). Dr. Abbas will evaluate me periodically during this treatment course.

6. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one third of the patients who participated in the research studies. I understand that I should inform Dr. Abbas or a member of the TMS Therapeutic staff if this occurs. The doctor may then adjust the dose or make changes to the where the coil is placed to help make the procedure more comfortable for me. I also understand that headaches were reported in half of the patients who participated in the clinical trial for the device. I understand that both discomfort and headaches got better over time in the research studies and that I may take common over-the-counter pain medications such as acetaminophen if a headache occurs.

The following risks are also involved with this treatment:

The TMS Therapy System should not be used by anyone who has magnetic-sensitive metal in their 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. An object that may have this kind of metal includes:

a.) Aneurysm clips or coils b.) Stents c.) Implanted Stimulators d.) Electrodes to monitor your brain activity e.) Ferromagnetic implants in your ears or eyes f.) Bullet fragments

- TMS 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.

- Seizures have been reported to occur rarely with TMS. There were no seizures in the clinical trials, which involved over 10,000 patient treatment sessions. The current estimated risk of seizure is 1 in 30,000 treatments (0.003%) or 1 in 1,000 patients (0.1%).

I understand that most patients who benefit from TMS Therapy experience results by the fourth week of treatment. Some patients may experience results in less time while others may take longer. I also 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. I have discussed it with Dr. Abbas and/or a member of his treatment team who has answered all of my questions.

I therefore permit Dr. Abbas or a member of the TMS NEURO NJ treatment staff to administer this treatment to me.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Jersey Shore Psychiatric Services, LLC
Office & Mailing Address: 5 Professional Circle, Suite 110 Colts Neck, NJ 07722-2427
Phone: (848)482-7764 Fax: (732)308-2227

Client's Name: _____ D.O.B._____

If client is a minor, person authorized to grant authorization:

Name: _____ Relationship to Client: _____

I authorize Dr. Muhammad Abbas, M.D. and his Jersey Shore Psychiatric Services, LLC. , associates and employees to share and receive confidential record information with and from the following person, people and/or agencies:

Name	Phone Number	Email	Address

Information shall consist of: Duplicate records and/or verbal consultation concerning treatment and/or education. Specifically:

- ☐ All Clinical Records
- ☐ Psychological Evaluation
- ☐ Educational Evaluation
- ☐ Medical History
- ☐ Social History
- ☐ Discharge Summary
- ☐ PCP Contract Form
- ☐ Master Treatment Plan
- ☐ Psychiatric Evaluation
- ☐ Mental Health Info
- ☐ Drug/Alcohol tests & results, diagnosis, treatment info
- ☐ Other: _____

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate one year from the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the director, therapists, employees and the above-named organizations from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information**) may be protected by Federal Regulations.

**Drug Abuse Office and Treatment Act of 1972 21 U.S.C. 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

_____ _____
Signature of Patient Date Witness Date

☐ I do not give my mental health provider permission to contact anyone beyond their legal responsibility as a mandated reporter in the State of New Jersey.

_____ _____
Signature of Representative Date Witness Date

*PRIVACY ACT STATEMENT: 1. The authority for soliciting the information comes from 10 USC 3012 2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking. 3. The information will be maintained under strict professional guidelines and until, by law, your records are released to be destroyed. 4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy

Welcome to TMS NeuroHealth NJ of JSPS, LLC. We appreciate the opportunity of being of service to you. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important that we communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff would be happy to help. By presenting these policies in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

Patient Financial Responsibility Agreement

Payment Responsibility: I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made.

Appointments & Cancellations: I understand that, I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for a cancellation fee of $10. TMS Neurohealth NJ may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may result in termination of therapy. There may be a time when the technician may need to cancel my appointment for an emergency; TMS Neurohealth NJ will make every effort to reschedule me in an appropriate time frame.

Returned Check Fee: I, the undersigned, agree to pay a fee of $25.00 for any check returned by my financial institution regardless of reason.

Delinquent Accounts: I understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Signature: _____ Date: _____

Printed Name: _____

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Full Name: Date of Birth:

Do you or have you had any of the following?

Seizure	Yes ☐ No ☐	Hearing Loss	Yes ☐ No ☐
Head Trauma	Yes ☐ No ☐	Ringing in your ears	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Claustrophobia	Yes ☐ No ☐
Brain Tumor(s)	Yes ☐ No ☐	Restless Leg Syndrome	Yes ☐ No ☐
Severe Headaches	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Eye Pain	Yes ☐ No ☐	Dizziness	Yes ☐ No ☐
Toothache	Yes ☐ No ☐		

Alcohol / Caffeine / Tobacco / Drugs

	Quantity	Frequency	Last Use
Alcohol			
Caffeine			
Tobacco			
Marijuana			

Other Drugs of Abuse

Drug	Quantity	Frequency	Last Use

Psychiatric History

Suicide Attempt(s) Yes ☐ No ☐ If Yes, When:

Thoughts of suicide: Yes ☐ No ☐

Psychiatric Hospitalization(s) Yes ☐ No ☐

Name of Hospital	Effectiveness (Effective or Ineffective)	Reason for Treatment	Date Started	Date Completed

Past IOP Treatment Program(s) Yes ☐ No ☐

Name of Program	Effectiveness (Effective or Ineffective)	Reason for Treatment	Date Started	Date Completed

Partial Care Treatment Program(s) Yes ☐ No ☐

Name of Program	Effectiveness (Effective or Ineffective)	Reason for Treatment	Date Started	Date Completed

Past Counseling Yes ☐ No ☐

Counselor Name	Reason for Counseling	Frequency per week	Date Started	Date Stopped	Effectiveness (Effective or Ineffective)

Have you ever had ECT? Yes ☐ No ☐

Date	Outcome	Unilateral / Bilateral
		Unilateral ☐ Bilateral ☐
		Unilateral ☐ Bilateral ☐
		Unilateral ☐ Bilateral ☐

Prescription medications you are currently taking:

Prescription Medication	Dosage	Frequency

WOMEN ONLY

Are you Pregnant? Yes ☐ No ☐

Date of last Menstrual Cycle:

Vitamins, supplements, or homeopathic medications you are currently taking:

Name	Dosage	Frequency

List all medical problems you have been or are currently being treated for:

List all surgeries you have had:

Procedure	Date	Outcome

Allergies, including medications: No known allergies ☐

Allergy / Medication	Reaction

Do you have any implanted metal objects around the head?
Plates: Yes ☐ No ☐ If yes, where?
Piercings: Yes ☐ No ☐ If yes, where?
Staples / Screws: Yes ☐ No ☐ If yes, where?
Stents: Yes ☐ No ☐ If yes, where?
Dental Implants: Yes ☐ No ☐ If yes, where?
Bullet Fragments: Yes ☐ No ☐ If yes, where?
Shrapnel Fragments: Yes ☐ No ☐ If yes, where?
Aneurysm Coils: Yes ☐ No ☐
Cochlear Implants: Yes ☐ No ☐
Ocular Implants: Yes ☐ No ☐
Deep Brain Stimulation Device: Yes ☐ No ☐
Other: Explain:
Do you have any of the following? :
Pacemaker: Yes ☐ No ☐
Hearing Aid: Yes ☐ No ☐ Removable? Yes ☐ No ☐
Implantable Cardiac Defibrillator (I.C.D.): Yes ☐ No ☐
Wearable Cardiac Defibrillator (W.C.D.): Yes ☐ No ☐
Vagal Nerve Stimulator (V.N.S.): Yes ☐ No ☐
Spinal Cord Stimulator: Yes ☐ No ☐
Implantable Drug Pump: Yes ☐ No ☐
Insulin Pump: Yes ☐ No ☐
Do you have anything not mentioned above implanted on your body? Explain:
I Certify that the information listed above is true and correct: X: _____ DATE: _____

TMS Antidepressant / Medication

**Please acquire your medication history from your pharmacy and submit with this paper work. **

Patient Name:				**Patient DOB:**	
Brand Name / Generic Name	**Current**	**Past**	**Dosage / Directions**	**Start / Stop Dates**	**Why Discontinued**
SSRI					
Prozac / Fluoxetine					
Zoloft / Sertraline					
Paxil / Paxil CR / Pexeva / Paroxetine					
Celexa / Citalopram					
Lexapro / Escitalopram					
Luvox / Fluvoxamine					
Viibryd / Vilazodone					
SNRI					
Effexor XR / Venlafaxine					
Cymbalta / Duloxetine					
Pristiq / Desvenlafaxine					
Fetzima / Levomilnacipran					
Savella / Milnacipran					
Other Antidepressants					
Wellbutrin / Aplenzin / Zyban / Bupropion					
Desyrel / Oleptro / Trazodone					
Remeron / Mirtazapine					
Serzone / Nefazodone					
Brintellix / Vortioxetine					
Tetracyclic / TCA					
Elavil / Endep / Amitriptyline					
Tofranil / Imipramine					
Norpramin / Pertofrane / Desipramine					
Pamelor / Aventyl / Nortriptyline					
Sinequan / Silenor / Doxepin					
Surmontil / Trimipramine					
Anafranil / Clomipramine					
Ludiomil / Maprotilene					
Asendin / Amoxapine					
Vivactil / Protriptyline					

Patient Name: **Patient DOB:**

Brand Name / Generic Name	Current	Past	Dosage / Directions	Start / Stop Dates	Why Discontinued
MAOI					
Nardil / Phenelzine					
Parnate / Tranylcypromine					
Marplan / Isocarboxazid					
Eldepryl / Selegiline					
Emsam / Selegiline patch					
Augmentation Agents					
Cytomel / Liothyronine / Thyroid T3					
Levothyroxine / Synthroid / Levoxyl / Thyroid T4					
Armour Thyroid / Thyroid T3 + T4					
Atypical Antipsychotics					
Abilify / Aripirazole					
Seroquel / Quetiapine					
Risperdal / Risperidone					
Saphris / Asenapine					
Fanapt / Iloperidone					
Zyprexa / Symbyax / Olanzapine					
Latuda / Lurasidone					
Invega / Paliperidone					
Clozaril / Clozapine					
Rexulti / Brexpiprazole					
Traditional Antipsychotics					
Thorazine / Chlorpramazine					
Mellaril / Thioridazine					
Loxitane / Loxapine					
Trilafon / Prephenazine					
Moban / Molindone					
Stelazine / Trifluoperazine					
Navane / Thiothixine					
Haldol / Haloperidol					
Prolixin / Flupherazine					

Patient Name:	**Patient DOB:**

Brand Name / Generic Name	**Current**	**Past**	**Dosage / Directions**	**Start / Stop Dates**	**Why Discontinued**
Stimulants					
Provigil / Modafinil					
Nuvigil / Armodafinil					
Adderall / Amphetamine					
Vyvanse / Lisdexamfetaine					
Concerta / Ritalin / Metadate / Methylphenadate					
Dexedrine / Dextroamphetamine					
Mood Stabilizers					
Lithobid / Eskalith / Lithium					
Lamictal / Lamotrigine					
Depakote / Valproate					
Tegretol / Equetro / Carbamazepine					
Trileptal / Oxycarbamazepine					
Lyrica / Pregabalin					
Neurontin / Gabapentin					
Benzodiazepines					
Xanax / Alprazolam					
Klonopin / Clonazepam					
Ativan / Temesta / Lorazepam					
Valium / Diazepam					
Librium / Chlordiazepoxide					
Serax / Oxazepam					
Tranxene / Clorazepate					
Other Antianxiety Agents					
Vistaril / Atarax / Hydroxyzine					
Buspar / Buspirone					
Sleep Agents					
Ambien / Ambien CR / Intermezzo / Zolpidem					
Lunesta / Eszopicione					
Sonata / Zaleplon					
Restoril / Temazepam					
Dalmane / Flurazepam					

Patient Name:	**Patient DOB:**

Brand Name / Generic Name	**Current**	**Past**	**Dosage / Directions**	**Start / Stop Dates**	**Why Discontinued**
Silenor / Doxepin					
Belsomna / Suvorexant					
Benadryl / Diphenhydramine					
Rozerem / Ramelteon					
Halcion / Triazolam					
Vitamins / Nutraceuticals					

***Please submit all information requested in this packet at your earliest convenience. We understand that it is lengthy, however, it is necessary for insurance authorization. ***

You can submit the TMS intake packet in one of the following ways in order to expedite the insurance authorization process:

- Email: mgallia@jshealth.org
- Fax: 732-308-2227
- Mail: Jersey Shore Psychiatric Services, LLC
  5 Professional Circle Suite 110
  Colts Neck, NJ 07722
- Or you may drop it off at the above location.