EMERALD TMS

CONFIDENTIAL CONTACT INFORMATION

Date: _____

Full Legal Name: _____ / _____ / _____
Last Name First Name Middle Initial

Preferred Name: _____ Age: _____ Date of Birth: _____

Social Security # _____

Address: _____ / _____ / _____ / _____
Street #/PO Box City State Zip Code

Telephone: (____)_____ **E-mail Address: _____**

Gender: (*Circle):* Female Male Gender Fluid Transwoman Transman Non-Binary

Prefer not to answer Other: _____

Emergency Contact: _____ / _____
Name *Relationship*

Emergency Contact Phone Number: (____)_____

Insurance Information:

Please make sure you have provided your insurance ID cards. If you do not have your card(s), complete the following:

Insurance: _____ Subscriber ID Number: _____

Group Name/Number: _____ Phone Number: _____

Claims Billing Address: _____

Communication:

Ok to leave a detailed message? (Circle) Yes / No

Is there anyone you would like to list besides yourself that we can discuss your medical information with?

Yes / No If yes, please sign Friends/Family Authorization HIPPA Form on the next page. Please also list any current doctors or psychiatrists you'd like to authorize to release information to Emerald TMS.

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AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I hereby Authorize:

NAME OF PERSON OR ORGANIZATION	**PHONE NUMBER**	**FAX NUMBER**
_____	_____	_____
_____	_____	_____
_____	_____	_____

To release specified information to:

Emerald TMS, LLC
1140 Willagillespie Road, Suite 44
Eugene, R 97401
Telephone: 541-735-3241
Fax: 541-735-3455

This information includes:

- ☐ Psychological Evaluation
- ☐ Listing of all medications
- ☐ Laboratory Reports
- ☐ Medical Records
- ☐ Psychotherapy Notes
- ☐ MRI/CT Imaging
- ☐ Other: _____

I understand this information is to be used for:

TMS Consultation
TMS Treatment
Evaluation
Treatment Planning

I understand this information will not be further released without my written consent. I understand that there are regulations protecting the confidentiality of authorized information but that such protection may not apply to the recipient of the information and therefore may not prohibit the recipient from re-disclosing the information I hereby acknowledge that this consent is voluntary and valid for 1 year or until this request is fulfilled. I acknowledge that I may revoke this consent at any time by doing so in writing delivered to the Covered Entity named above and that the revocation will not apply to the use or disclosure of any information that was made pursuant to this authorization before it is revoked. I also understand that the Covered Entity may not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed knowing that action may have already been taken.

_____ _____

Signature of Patient or representative Relationship

_____

Date

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MEDICATIONS-Do you have a list? If yes, we'll make a copy instead.
Please list all medications and supplements

Patient Name: _____

Medication	Dose	How Often	Prescribing Doctor

You may use the back of this page

Depression Medication(s) Tried & Failed	Dates used & Reason for Discontinuation

Allergies	Reaction

Other Medication/Supplement Information:

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CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____

Most Recent Primary Care Information:

Physician's Name: _____ Phone: _____

Most recent appointment: _____

Psychiatrist or other specialist: _____ Phone: _____

Most recent appointment: _____

Psychologist or Therapist Name: _____ Phone: _____

Most recent appointment: _____

Other Specialist: _____ Phone: _____

Most recent appointment: _____

Do you have any of the following? (If yes, please circle)

Aneurysm Clip or Coil

Pacemaker

Stent in the neck or brain

Deep Brain Stimulator

Electrodes to monitor brain activity

Metallic implants in your ears and/or eyes

Shrapnel or bullet fragments in or near the head

Facial tattoos with metallic or magnetic – sensitive ink

Other metal devices or object implanted in or near the head

Head Injury

Seizures (past or current)

Cardiovascular disease (past or current)

Current or possible pregnancy

Concussion

Coma

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REFERRAL INFORMATION

Patient Name: _____

Referred by: _____ Phone Number: _____

How did you hear about us? _____

Personal Habits (indicate frequency and quantity per daily use)

- ☐ **Alcohol** _____
- ☐ **Tobacco** _____
- ☐ **Marijuana/Cannabis or Other Recreational Drugs**_____
- ☐ **Caffeine**_____

Social History

a) Highest Level of Education _____

b) Marital status:

- ☐ Single
- ☐ Married/Partnered
- ☐ Divorced
- ☐ Widowed

Do you currently serve, or have you served in the military? Yes / No

Branch of service: _____

Active Veteran (*circle)* Other: _____

Occupation: _____ (Circle) Full Time/ Part Time

Place of employment: _____

Ethnicity: (*circle)*

White
African American
Hispanic or Latino
Native American or Alaska Native
Asian American
Native Hawaiian or other Pacific Islander
Middle Eastern
Prefer not to answer Other: _____

Emerald TMS does not and shall not discriminate on the basis of race, color, religion (creed) gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

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FAMILY HEALTH HISTORY

Patient Name: _____

Please indicate if any family member (other than patient) has had the following:

	Birth Mother		Birthfather		Biological brother		Biological sister		Biological grandparents	
	Yes		**Yes**		**Yes**		**Yes**		**Yes**	
Depression										
Mania (Bipolar)										
Psychosis (Schizophrenia)										
Anxiety										
Panic Attacks										
Obsessive Compulsive										
Tics or Tourette's										
Alcoholism										
Drug Dependence										
Been Abused										
Asperger \ Autism										
Sleep Apnea										
Seizures										
Asthma										
Bowel Disease										
Skin Disease										
Heart Disease										
Diabetes										
Obesity										
Criminal Conviction										
Psychiatric Hospital Stay										
Inpatient Drug and Alcohol										
Suicide										

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Patient Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Emerald TMS. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, it will become available upon request to patients or other persons on or after the effective revision.

I acknowledge receipt of the Notice of Privacy Practices from Emerald TMS.

PATIENT FINANCIAL RESPONSIBILITY

Emerald TMS is committed to providing you with the best possible care and will help you receive your maximum allowable insurance benefits. We are here to help you and will be happy to answer any questions about your insurance coverage.

With your signature below, you hereby acknowledge and authorize the following:

1. Assignment of insurance benefits to Emerald TMS. This is to include private insurance and Medicare. In doing so, you authorize release of any information necessary to process claims on your behalf.

2. Financial Responsibility. You agree, in consideration of services rendered by Emerald TMS, to be responsible for payment in full, including any collection or attorney's fees related to non-payment when payment is due. All payments are due upon receipt of the bill.

Emerald TMS will submit your claim to your insurance plan. It is the responsibility of the patient to provide the practice with updated demographic and insurance information for accurate billing. Due to current regulations all co-payments, deductibles, or non-covered services must be paid at the time of service, unless a payment agreement has been established. For patients who do not have health insurance, payment in full is required at the time of the visit for all services, unless a payment agreement has been established.

_____ _____

Signature of Client Date

_____ _____

Parent/Guardian Date

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Name_____ Birthdate_____Date_____

PHQ-9 Health Questionnaire

Response Table:
0 = Not at all | 1 = several days | 2 = more than half the days | 3 = nearly every day

Over the last 2 weeks, how often have you been bothered by any of the following problems?

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 having 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

Total score: ___

Also, 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