



## 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.

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.



**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



**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:**



**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

Head Injury

Pacemaker

Seizures (past or current)

Stent in the neck or brain

Cardiovascular disease (past or current)

Deep Brain Stimulator

Current or possible pregnancy

Electrodes to monitor brain activity

Concussion

Metallic implants in your ears and/or eyes

Coma

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



## 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: \_\_\_\_\_ Do you currently serve, or have you served in the military? Yes / No

- Single \_\_\_\_\_ Branch of service: \_\_\_\_\_
- Married/Partnered \_\_\_\_\_
- Divorced \_\_\_\_\_ Active Veteran (*circle*) Other: \_\_\_\_\_
- Widowed \_\_\_\_\_

Occupation: \_\_\_\_\_ (Circle) Full Time/ Part Time

Place of employment: \_\_\_\_\_

### Ethnicity: (*circle*)

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

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## FAMILY HEALTH HISTORY

Patient Name: \_\_\_\_\_

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

	Birth Mother		Birth Father		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										



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



**Patient:**

**Date:**

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

PHQ-9		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

**Total Score: \_\_\_\_\_**

GAD-7		Not at all	Several Days	More than 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

**Total Score: \_\_\_\_\_**