

Diplomate American Board of Psychiatry & Neurology $\textbf{1} \mid P \text{ a g } e$

	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:	



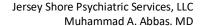
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Patient Consent for TMS Therapy

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.





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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 mem	ber of the TMS NEURO NJ treatment staff to admir	nister this treatment to me.
SIGNATURE:	DATE:	
PRINT NAME:		

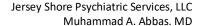


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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION Jersey Shore Psychiatric Services, LLC

Client's Name:		D.O.B		
If client is a minor, person a	authorized to grant authoriza	ation:		
Name:	Re	elationship to Client:		
	Abbas, M.D. and his Jersey			
share and receive confiden Name	Phone Number	and from the following Email	person, people and/or age Addres	
Name	i none Number	Linaii	Addies	3
 □ All Clinical Records □ Psychological Evaluation □ Educational Evaluation □ Medical History □ Social History The information is need continuity of care for this purpose 		ummary Det Form diagonate Form Det Form	rug/Alcohol tests & results, gnosis, treatment info hther:	ire and maintaining a
transpired. If not revoked, it shall A photocopy, facsimile of	be revoked at any time by the clier terminate one year from the last di or duplicate copy of this authorizati	ay of the clinical treatment. ion shall be as valid as the c	riginal.	·
medical records.	as a right to receive a copy of it. M			
employees and the above-named certain medical records (including	rand the nature of this release. I use organizations from any liability that any alcohol and drug abuse informent Act of 1972 21 U.S.C. 1175; Co.C. 4582).	at may arise from this action mation**) may be protected b	whether or not foreseen at prese by Federal Regulations.	nt. I understand that
Signature of Patient	Date	Witness	Date	
reporter in the State of New	health provider permission to Jersey.	ю сонтаст ануоне веус	ond their legal responsibilit	.y as a manuated
Signature of Representative	e 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:		



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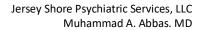
NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Information	on								
Full Name:	Date of Birth:								
Do you or have yo	u had any of the following	g?							
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 □								
	A	alcohol / Caffeine / Tobacco / Drug	(S						
	Quantity	Frequency	Last Use						
Alcohol									
Caffeine									
Tobacco									
Marijuana									
		Other Drugs of Abuse	,						
Drug	Quantity	Frequency	Last Use						



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			Psych	iatric Hist	ory		
Suicide Attempt(s)	Yes □ N	lo 🗆			If Yes, When:		
Thoughts of suicide:	Yes 🗆	No □					
Psychiatric Hospitaliz	cation(s) Ye	s 🗆 No					
Na	ime of Hosp	oital		Effectiveness (Effective or Ineffective)	Reason for Treatment	Date Started	Date Completed
Past IOP Treatment I			No 🗆			T	
Na	me of Prog	ram		Effectiveness (Effective or Ineffective)	Reason for Treatment	Date Started	Date Completed
Partial Care Treatme	nt Progran	n(s) Yes	□ No □				
Na	ime of Prog	ram		Effectiveness (Effective or Ineffective)	Reason for Treatment	Date Started	Date Completed





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Past Counseling Yes Counselor Name	□ No □ Reason for Counsel	ling Frequency	Date Started	Date Stopped	Effecti	veness
		per week			(Effective or	
Have you ever had E	CT? Yes \(\text{No } \(\text{\text{\text{No }} \(\text{\text{\text{\text{\text{C}}}}} \)					
					****	/D'1 1
Date	2		Outcome		Unilateral	
					Unilateral	Bilateral
					Unilateral	Bilateral
					Unilateral	Bilateral
Prescription medic	pations von aro an	rontly talzing				
Prescription In Indian I			osage		Frequency	
WOMEN ONLY						



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Vitamins, supplements, or homeopathic medications you are currently								
taking: Name	Dosage		Frequency					
Name	Dosage		rrequency					
List all medical problems you have for:	been or are currently	y being treated						
List all surgeries you have had:								
Procedure	Date		Outcome					
Allergies, including medications:	No known a	llergies						
Allergy / Medication	on		Reaction					



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Do you have any implanted metal objects around the head?
Plates: Yes \(\text{No} \(\text{If yes, where?} \)
• /
Piercings: Yes \square No \square If yes, where?
Staples / Screws: Yes □ No □ If yes, where?
Stents: Yes \(\text{No} \(\text{No} \) \(\text{If yes, where?} \)
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 \(\text{No} \(\text{No} \)
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:



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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 /	Start / Stop Dates	Why Discontinued
SSRI			Directions		
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					



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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						



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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						



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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:

Address: 35 Beaverson Blvd, 4C, Brick, NJ, 08723

Contact:732 532 4564