Name: DOB:

Payment Arrangements for Non-Insured Services or Patient Responsibility

Int. _____ I agree to pay_____ upfront then pay each week as follows:_____

Int. _____ I understand and agree that I have co-pays, co-insurance, deductible or other out-of-pocket amounts that shall be paid in installments prior to each treatment or as approved in writing.

Int. _____ I understand that TMS Wellness Institute may not participate or may be out of network with one or more of my insurance policies (i.e. Medicaid etc.) and that I am ultimately responsible for any amounts not covered by that policy; or, I have elected to pay for my treatment out-of-pocket regardless of my insurance coverage.

Int. _____ I understand these arrangements are being made for my co-pays or any other non-insured or patient assigned responsibilities from my insurance company.

Int. _____ I understand my deductible may or may not be met, and if not met, will need to be added as soon as this is known, and your payment amount would need to be increased.

Int. _____ I understand any changes to my insurance, employment, or standing with my insurance company, will result in treatment being denied and financial responsibility falling to me.

Notes: _____

_____

Signed: _____ Date: _____

Relationship to patient: _____

Name: DOB:

GOOD FAITH ESTIMATE-INSURANACE

Date: _____

The estimated total is_____for TMS treatment scheduled through_____.

The estimate below is our best calculation of the TMS treatment that is likely for your prescribed care over the estimated time period covered. This is only our best estimate based on insurance information gathered from your carrier. Your out-of-pocket expenses, including co-insurance, co-pays and deductibles for this treatment, may be more or less than what is stated. We will update you as soon as we are aware of any increase or decrease.

If you have questions about this good faith estimate, please contact Donald at 256-294-1727.

Treatment Description Total Cost	**Estimate** **Patient to Pay**
Psychiatric Evaluation MT & 1st Treatment Each treatment x 35 Deductible	Copay Coinsurance + any outstanding deductible.

Disclaimer: This Good Faith Estimate shows the current costs of services that are reasonably expected for the specific services to address your mental health care needs. The estimate is based on the information known to TMS Wellness Institute and does not include any unknown or unexpected charges **you may be responsible for** that may arise during treatment.

Signature: _____ **Date**: _____

For Parent/Guardian for patients under 18 years of age:

Signature: _____ **Date**: _____

Name: DOB:

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing TMS Wellness Institute for your Transcranial Magnetic Stimulation treatment (TMS). Because we are committed to providing you with the highest quality healthcare, we ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding their primary, as well as secondary insurance. Patients are responsible for payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered or approved by your insurance plan. Copays are due at the time of service. Payment Plans are available for self-pay and/or remaining balance.

Patient Name: _____ **DOB:** _____

_____ _____

Signature: Patient/Guardian/Responsible Party* **Date**

**All patients under 18 years of age must have a parent, guardian, or responsible party signature before beginning TMS Treatment.*

Name: DOB:

AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Patient Name:	DOB:

I hereby request and authorize **TMS Wellness Institute**

to disclose, to receive from, and communicate with:

1.Facility/Doctor _____

Facility Phone: _____ Facility Fax: _____

2. Personal Representee: _____

Relationship: _____ Phone: _____

The purpose of disclosure is for exchange of information between the individual/facility listed above and this agency in order to provide continuity of care.

The date this consent expires: 364 days from date of patient signature below.

Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" under state law G.S. 122C for mental health.

I may revoke this authorization at any time.

REVOCATION OF AUTHORIZATION/CONSENT

I withdraw the authorization to disclose personal health information of

_____

(Verbal Request by: _____)

effective on_____

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Parent/Guardian if Patient under 18 Date

_____ _____

Staff Signature Date

Name: DOB:

EMERGENCY MEDICAL INFORMATION
PERSON(S) TO CONTACT IN CASE OF EMERGENCY

Name:	Relationship:	Address:
Home Phone:	Work Phone:	Mobile Phone:
Name:	Relationship:	Address:
Home Phone:	Work Phone:	Mobile Phone:

PRIMARY CARE PROVIDER INFORMATION

Practice:	Physician's Name:	Address:
Phone:	Fax:	

_____ _____

Signature Date

Name: DOB:

Patient Information for TMS Treatment

This is a patient informational sheet for a medical procedure called NeuroStar TMS Therapy. This information outlines the treatment that your provider has prescribed for you, the risks of this treatment, and the potential benefits of this treatment to you.

TMS Wellness Institute:

1. Is providing TMS therapy for the treatment of depression. Any additional benefits that may be derived from the therapy would be considered an “off label” benefit.
2. Does not provide medical services and will NOT act as the patient’s physician. All medical care normally performed by a PCP or a Psychiatrist will be obtained from a medical practice secured by the patient.
3. Does NOT prescribe any medications or perform medication management.

TMS stands for *Transcranial Magnetic Stimulation.*

1. NeuroStar TMS Therapy is a medical procedure.
2. A TMS treatment session is conducted using a device called the NeuroStar TMS Therapy System, which provides electrical energy to a *treatment coil* or magnet that delivers pulsed magnetic fields.
3. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines.

NeuroStar TMS Therapy is a safe and effective treatment for patients with depression who have not benefitted from antidepressant medications.

1. Specifically, NeuroStar TMS Therapy has been shown to relieve depression symptoms in patients over 15 years of age who have been treated with prior antidepressant medications but did not get better.
2. The safety and efficacy of NeuroStar TMS Therapy has not been established in patients who did not take any antidepressants during the current episode of depression.

During a TMS treatment session:

1. The provider or a member of their staff will place a magnetic coil gently against my scalp on the left front region of my head.
2. The magnetic fields that are produced by the magnetic coil are pointed at a region of the brain that scientists think may be responsible for causing depression.

3. To administer the treatment, the provider, or a member of their staff, will first position my head in the head support system.
4. Next, the magnetic coil will be placed on the left side of my head, and I will hear a clicking sound and feel a “tapping” sensation on my scalp.
5. The provider will then adjust the NeuroStar TMS Therapy System so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right hand twitches.
    a. The amount of energy required to make my hand twitch is called the *Motor Threshold.*
    b. Everyone has a different motor threshold, and the treatments are given at an energy level that is just above my individual motor threshold.
    c. How often my motor threshold will be re-evaluated will be determined by the provider.
    d. Once the 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 11-26 seconds between each series.
    e. Treatment is to the left front side of my head and will take about 18-40 minutes.
    f. I understand this treatment does not involve any anesthesia or sedation, and I will remain awake and alert during the treatment.
    g. I will likely receive treatments 5 times per week for 6-7 weeks (30 – 36 treatments).
6. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on.
    a. These types of sensations were reported by about one third of the patients who participated in the research studies.
    b. I understand that I should inform the provider or his/her staff if this occurs.
    c. The provider may then adjust the dose or make changes to where the coil is placed to help make the procedure more comfortable for me.
    d. I also understand that headaches were reported in half of the patients who participated in the clinical trial for the NeuroStar device.
    e. 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 if a headache occurs.

The following risks are also involved with this treatment:

Name: DOB:

1. The NeuroStar TMS Therapy System should not be used by anyone who has magnetic-sensitive metal in their head or within 12 inches of the NeuroStar magnetic coil that cannot be removed.
    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
    g. Other metal devices or objects implanted in the head
    h. Facial tattoos with metal ink or permanent makeup
        a. The NeuroStar TMS System should be used with caution in patients who have pacemakers or implantable cardioverter defibrillators (ICDs) or are using a wearable cardioverter defibrillator (WCD)
2. Failure to follow these restrictions could result in serious injury or death.

NeuroStar TMS Therapy is not effective for all patients with depression.

1. Any signs or symptoms of worsening depression should be reported immediately to your provider.
2. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.

Seizures (sometimes called convulsions or fits) have been reported with the use of TMS devices.

1. However, no seizures were observed with use of the NeuroStar TMS Therapy System in over 10,000 patient treatment sessions in trials conducted prior to FDA clearance of the NeuroStar TMS System.
2. Since the introduction of the NeuroStar TMS System into clinical practice, seizures have been rarely reported.
3. The estimated risk of seizure under ordinary clinical use is approximately 1 in 30,000 treatments or 1 in 1000 patients.

I understand that I must wear earplugs or similar hearing protection devices with a rating of 30dB or higher of noise reduction during treatment. The NeuroStar TMS Therapy System produces a loud click with each magnetic pulse.

Name: DOB:

I understand that most patients who benefit from NeuroStar TMS Therapy will not experience positive results after completion of treatment (approximately 7 weeks). Some patients may experience results in less time while others may take longer.

I understand that I may discontinue treatment at any time.

I acknowledge that I have read and understood the preceding information, including possible side effects.

I will speak with the provider or a staff member about any questions or concerns I may have regarding my TMS Treatment.

_____

Signature Date

Name: DOB:

HIPAA RIGHTS

I understand I have the following rights as a patient of TMS WELLNESS INSTITUTE.

1. To be informed of and receive a copy of my Patient Rights.
2. To receive services regardless of race, sex, creed, color, physical or mental handicap.
3. To know the reasons for and/or purpose of the services provided.
4. To be informed of initial assessment findings and discuss with a clinician the possible treatment method available to me, including benefits and possible risk at intake.
5. To receive Orientation to Treatment during my intake so I can understand the treatment process.

I understand I have the right to confidentiality under federal confidentiality rules (45 C.F.R. Parts 160 and 164- the "Privacy Standards" and 42 C.F.R. Parts 2).

I understand that Federal law and regulations protect the confidentiality of patient records maintained by TMS Wellness Institute. We may not say to a person outside the agency that you participate in services **unless:**

1. You consent in writing; or
2. You threaten to hurt self or someone else; or
3. The disclosure is allowed by a court order, with a subpoena, specifically authorizing disclosure.

I understand that my rights and confidentiality laws have been explained to me.

1. I agree with each of them and still want to participate in treatment at TMS Wellness Institute.
2. I understand I may withdraw this consent at any time.

I understand I have the right to get a list of disclosures.

1. You must make the request in writing. The list will not include the times that information was disclosed for treatment, payment, or healthcare operations.
2. The list will not include information provided directly to you or your family or information sent with your authorization.

(Con't)

Name: DOB:

HIPAA RIGHTS (Con't.)

I understand I have the right to receive a copy of *The Notice of Privacy Practices* and any revisions thereafter.

1. The terms of this notice may be changed in the future, and these changes will be posted in the waiting room and in the Client Handbook.
2. You may also request a copy of the new Notice by contacting the Privacy Officer at 256-294-1727.

I understand I may file a complaint about our Privacy Procedures:

1. If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies and procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if a complaint is filed.
2. If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies and procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if a complaint is filed.
3. To file a complaint with the agency, you may bring your complaint to any agency location, or you may contact the Privacy Officer at 256-294-1727.
4. To file a complaint with the Federal Government, you may send a written complaint to Atlanta Federal Center, Region IV, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909 or you may call 404-562-7886.

_____ _____

Patient/Parent/Legal Representative/Guardian Signature Date

Name: DOB:

PATIENT RIGHTS AND RESPONSIBILITIES. MAKING OUR RELATIONSHIP WORK WELL.

At TMS Wellness Institute, our mission statement to you, our patient is:

To utilize the latest technology to provide clinically proven results for those who struggle with severe depression. We will strive to always provide a skilled, compassionate, and professional team that forms the caring culture of our clinics.

Our staff:

Dr. Archibald is a Board eligible licensed psychiatrist. He completed his residency training in General Adult Psychiatry at New York Medical College, NewYork, his Medical training at St. George's University School Of Medicine, and his undergraduate training at Long Island University, NY and Aberdeen University, Aberdeen, Scotland UK.

Dr. Archibald treats a wide range of psychiatric conditions, specializing in Addiction Psychiatry, resistant Major Depressive Disorders, Severe Anxiety disorders, Bipolar disorders and ADHD.

He is trained and qualified as a psychiatrist to use the latest technologically advanced methods to treat Resistant Depressive Disorders. TMS, Transcranial Magnetic Stimulation, bridges the gap between antidepressant medication and electroconvulsive therapy.

TMS Wellness Institute is dedicated to providing certified, trained technicians for your TMS treatments. You have the right to ask questions, make a complaint, or comment about the treatment received. Please address your concerns to one of our TMS coordinators.

Expectations of Treatment:

You are expected to take responsibility for identifying and communicating with our staff any personal or physical problems that may affect your treatment in any way.

We expect everyone to conduct themselves in a polite and courteous manner. Disruptive, inappropriate, abusive, or violent language or behaviors will not be tolerated and may result in termination from the program without refund.

We have the right to deny a session to a patient if we suspect, for any reason, that the patient may be impaired. For consistent issues, we reserve the right to terminate the treatment.

Name: DOB:

Appointments and Cancellations:

Please be on time for your scheduled appointment. Try to arrive 10 minutes before your scheduled time. Please cancel or reschedule your appointment 24 hours in advance. If you are more than 10 minutes late without calling, we reserve the right to cancel or reschedule your appointment. In the event you do not show for your appointment, with no advanced notice, we reserve the right to dismiss you as a patient.

If you have a fever of 100.4, please call to cancel your appointment.

Only service dogs are allowed at your appointments

Appointments are made at our Anniston office by calling 256-294-1727.

Appointments are made at our Birmingham office by calling 205-578-2393

Billing questions, call Donald Watkins at our Main office 256-294-1727.

Electronic communication:

We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. However, if you prefer to communicate through text messaging or email for issues regarding scheduling or cancellations, we will do so. Videotaping, in our office or of the procedure, is strictly prohibited unless with prior written, management approval.

Safety Procedures:

In case of an emergency, leave the building through the nearest exit and walk to the parking lot. Remain with staff and patients until an "All Clear" is given.

Severe Weather:

In case of severe weather, please call the office at 256-294-1727 to see if we are operating on normal business hours. If we must close, we will call you as soon as we re-open to reschedule your missed appointments.

_____ _____

Signature Date