PATIENT INFORMATION

FIRST NAME_____MIDDLE INITIAL_____LAST NAME_____

SEX**: M F T** DOB_____ MARITAL STATUS_____ SS# _____

RACE: Caucasian African American Asian Hispanic American Indian/ Alaskan National Multi-Racial

PERMANENT MAILING ADDRESS_____APT/LOT#_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE_____WORK PHONE_____ MOBILE PHONE_____

EMAIL_____

REFERRED BY:

_____

REASON FOR VISIT:

_____

CIRCLE PREFERRED METHOD OF COMMUNICATION:

EMAIL CELL HOME PHONE **OK TO LEAVE VOICE MAIL Yes // No**

I would like to receive text messages for appointment reminders, or other TMS updates. I understand that I can opt out at any time. **Yes // No**

CIRCLE EMPLOYMENT STATUS: EMPLOYED SELF UNEMPLOYED DISABLED RETIRED STUDENT

EMPLOYER_____OCCUPATION_____

PREFERED PHARMACY: _____ Address_____PHONE_____

PRIMARY PHYSICIAN:

NAME:_____PHONE_____

PSYCHIATRIST:

NAME:_____PHONE_____

THERAPIST:

NAME:_____PHONE_____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME OF PERSON TO CONTACT:_____PHONE: _____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER INFORMATION

FIRST NAME_____MIDDLE INITIAL_____LAST NAME_____

DATE OF BIRTH_____SS #_____

EMPLOYER_____ PHONE_____

INSURANCE COMPANY INFORMATION

PLEASE PRESENT YOUR INSURANCE CARDS TO PHOTOCOPY AND TELL US THE FOLLOWING:

NAME OF PRIMARY **INSURANCE** _____

POLICY #_____GROUP#_____

IF WE **DO NOT** PARTICIPATE WITH YOUR INSURANCE PLAN, WE WILL ASK YOU TO PAY IN FULL AT THE TIME OF SERVICE AND AS A COURTESY WE WILL HELP YOU SUBMIT A CLAIM TO YOUR INSURANCE COMPANY.

SPECIAL NOTE ABOUT MENTAL HEALTH DISABILITY AND WORKMAN'S COMP EVALUATION: INITIAL: _____
WE DO NOT COMPLETE FORMS FOR DISABILITY APPLICATION/CONTINUATION OR WORKMAN'S COMPENSATION EVALUATION OR CLAIMS. WE DO NOT FILL OUT FORMS FOR PSYCHIATRIC OPINION REQUESTED FROM LEGAL COUNSEL.

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN: _____

DATE:_____

RELATIONSHIP TO PATIENT: _____

CONSENT FOR TREATMENT

I Acknowledge that I will be receiving **only** TMS Treatment. All medication management and other related services should be managed by my current primary care physician or prescribing psychiatrist.

PRINT NAME_____ SIGN_____ DATE_____

HIPAA POLICY & PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirement officially began on April 14, 2003. Many of the policies have been our practice for years. This is an abbreviated version; however, the complete text is available in our offices or on the U.S. Department of Health and Human Service website: www.hhs.gov

HIPAA states that there are rules and restrictions who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with our office medicals services.

Your information will be kept confidential up to 12 months, except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers if desired, laboratories and health insurance payers as is necessary and appropriate for your care.

Our Electronic Medical Records (EMR) is secure and personal information is encrypted to insure confidentiality. General information which does not include any client identifiers may be used in retrospective studies. However, studies requiring any personal identifiers will require your approval and consent.

It is policy of this office to remind clients of their appointment. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

We agree to provide clients access to their records in accordance with state and federal laws. You understand and agree to inspection of the office and review of document which may include PHI by government agencies or insurance payers in normal performance of their duties.

We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the clients. You have the right to request restrictions in the use of your protected health information as the law permits. Your confidential information will not be sold for any reason.

Your signature will indicate that you have read the HIPAA information and consent to the guidelines set forth in the Act.

Patient Signature _____ Date _____

Print Name _____

Witness Signature _____ Print Name _____

Please Fax Records to: 414-774-1488

Authorization for Release of Protected Health Information (HIPAA Compliant)

Patient Name:_____ Date of Birth: _____

Family Member/Clinician/Pharmacy	Contact Number	Fax Number

1. I_____, hereby authorize the above- named person or entity, its agents, employees and associates (the "Disclosing Party"), to release the protected health information described below **to/from SuccessTMS**, its agents, employees and associates for up to 12 months. 2. The Protected health information to be disclosed is described as follows:

- ☐ My entire medical records including, but not limited to, any and all reports, and any notes (doctor's nurses, and physical therapists) consultation reports and records, tests, test results, x-ray report, radiology reports, patient form pharmacy record, correspondence, notes, and memorandum, billing information, insurance information and invoice related to my care and treatment rendered at any time or date by or through Disclosed party's office.
- ☐ The following specific protected health information:

_____

_____

3. The protected health information is to be disclosed for the following purposes:

_____

4. I understated that I may revoke this authorization in writing at any time by sending a written revocation to the Disclosing Party's address set forth above, provided that this authorization cannot be revoked as to protected health information that has previously been released in reliance on this document.
5. I understand that a refusal to sign this authorization will not result in a denial of health care by the Disclosing Party or any other health care provider.
6. I understand that once the protected health information is disclosed, it may be re-disclosed individuals or organization that are not subject to the federal privacy regulations and would no longer be protected by those regulations.
7. I understand that I am entitled to a copy of this authorization.
8. I acknowledge the Disclosing Party and its agents, employees and associates are released from legal responsibility or liability for release of the above- described protected health information to the extent indicated and specifically authorization herein.

Patient/Authorized Person Signature_____ Date _____

Success TMS
James Winston, M.D.,
10424 W. Bluemound Rd Milwaukee, WI 53226
P: 414-219-9485
F: 414-774-1488

OUR FINANCIAL & CANCELATION POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. The patient agrees to pay the patient responsibility at the time of service.
2. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. We also work with Advance Care Card, please ask staff for details
3. Check return fee is $25.00.
4. Patient is responsible for notifying Success TMS of any changes in insurance. If fees accrue due to an unreported change of insurance, the patient is responsible for any non-covered service fees.

I have read and understand **Success TMS** Financial Policy and I agree to be bound by the terms above.

Initial of Responsible Party _____

Thank you for entrusting your care to SuccessTMS. We strive to render excellent care to you, your family, and all of our patients. In order to be consistent with this philosophy, SuccessTMS. uses an appointment system that sets aside ample time for a patient, dependent on the patient's current needs. Due to the limited number of times available, we encourage you to keep your appointment.
I agree to the following policy:

1. That I will give your office a 24-hour notice in event that I need to reschedule my appointment. This will make the appointment time available to someone else. Our scheduling number is 561-763-7629.
2. As a new patient, if I miss an appointment and do not contact the office with at least 24 hours' notice, the office will consider this to be a no-show appointment and a $100.00 fee will be assessed to me.
3. As a follow-up patient, if I miss an appointment and do not contact the office with at least 24 hours prior notice, the office will consider this to be a no-show appointment and a $100.00 fee will be assessed to me
4. If I am late for my appointment, I will be seen if time permits. Otherwise I may need to reschedule my appointment and might be considered as a no show.
5. As a courtesy, when time allows, we make reminder calls for appointments. If I do not receive a reminder call or message, the cancellation policy will remain in effect.

_____ _____

Signature of Patient (Parent/Legal Guardian) Date

_____

Name of Patient (Printed)

Patient Medical History

PAST MEDICAL HISTORY: Do you have or have ever had any of the following? (Circle all that apply)

Arthritis	**Lung Disease**	**Sleep Apnea**	**Urinary Tract or Kidney Problems**
Diabetes	**Seizures**	**Genital Problems**	**Gynecological/Hysterectomy**
Viral Illness	**Anemia**	**Eating Disorder**	**HIV Positive or AIDS**
Skin Disease	**Injury**	**Cochlear Implants**	**Neurological Problems**
Cancer	**Fibromyalgia**	**High Cholesterol**	**Endocrine/Hormone**
Heart Disease	**Thyroid**	**High Blood Pressure**	**Ear, Nose, Throat problems**
Asthma	**Eye Problems**	**Chronic Pain**	**Liver Damage or Hepatitis**
Other	**Gastrointestinal Problems**	**Joint Problems**	**Migraine or Cluster Headaches**

List all prior major surgeries:

_____ _____

_____ _____

MEDICAL DEVICES: Please Circle

Do you have any implantable or wearable cardiac implants? Yes // No
Do you have metallic, electronic, or magnetic implants above your shoulder? Yes // No Do you have a cochlear implant or Vagus Nerve Stimulator (VNS)? Yes // No
FOR WOMEN ONLY:
Are you currently pregnant or a possibility you may be pregnant? Yes // No

ALLERGIES: Are you allergic to any medication? ( ) YES ( ) NO If so, please list below:

Medications	Reactions

Psychiatric medication tried in the PAST:

MEDICATION	DIAGNOSIS	MEDICATION	DIAGNOSIS
1		**5**	
2		**6**	
3		**7**	
4		**8**	

List ALL Current Medications and Dosages Taking:

Medication	**Dosage**	**Medication**	**Dosage**	**Medication**	**Dosage**
1		**4**		**7**	
2		**5**		**8**	
3		**6**		**9**	

PAST PSYCHIATRIC HOSPITALIZATIONS/PHP/IOP:

HOSPITAL	**REASON**	**DATES**

FAMILY PSYCHIATRIC HISTORY:

	Relative		Relative
Depression		**Bipolar Disorder**	
Panic Attacks		**ADHD**	
PTSD		**Addiction**	
OCD		**Schizophrenia**	
Eating Disorder		**Suicide Attempts/Completions**	

Patient Adopted History: ( ) YES ( ) NO ( ) Unknown

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widow(er)

Social History: Check all that apply:

Education: ( ) HS ( ) GED ( ) AA ( ) College Grad

Lives With: ( ) Spouse ( ) Children ( ) Mom ( ) Step Mom ( ) Dad ( ) Step Dad ( ) Siblings ( ) Other

History of Trauma Abuse ( ) YES ( ) NO

SUBSTANCE ABUSE HISTORY:

	PAST USE	CURRENT USE
THC		
IV DRUG USE		
OPIATES		
BENZODIAZEPINES		
STIMULANTS		
COCAINE		
ALCOHOL		
TOBACCO		

SuccessTMS
LEAVING DEPRESSION BEHIND

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name_____ Date_____

Provider _____ Patient ID # _____

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

add columns: _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:** _____

10. 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** _____

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