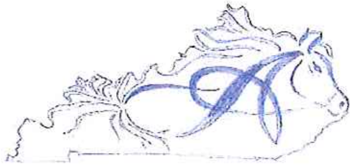


Lexington TMS

Dear Client:

Thank you for choosing Lexington TMS to be your TMS therapy provider. We understand that you have tried many treatments for your mental condition, but you still are suffering. We will provide you with the cutting-edge medical treatment and always treat you like a person and not just a patient.

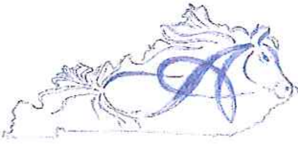
Unfortunately, **most insurance networks require a prior authorization** before you begin therapy. So, to help protect each of our patients, **we ensure appropriate authorization** from your insurance is obtained before you begin treatment.

We have designed our **TMS Registration Form based on the information that will be required on your insurance's prior authorization form, so please be as thorough as possible. If you cannot remember specific dates, especially where previous medications are concerned,then just list an approximate date, including month and year.**

Most insurances will require the following:

- A diagnosis of depression (moderate to severe)
- A minimum of 2-4 antidepressant trials
- A history of psychotherapy (therapist, counselor, group therapy, outpatient therapy, extended visits with a psychiatrist or psychologist)
- PHQ-9 (Depression screening) score > or = 18

We thank you for taking the time to complete our TMS Registration and look forward to helping you to achieve long-term relief from your depression.



Patient Registration Form **Today's Date:**___________

Patient's Full Name:________________________________Date of Birth:_____/____/____

Gender:__________Client's SSN:______________________________*Used for Insurance Reasons*

Mailing Street & Apt#:____
*I understand that by giving this address, statements and necessary forms will be mailed to the address provided. *

City:______________________________State:______________Zip Code:______________

☐ Address has been verified by USPS.com/zip4 (Office Use)

Marital Status of Client: ☐ Single ☐Married ☐Divorced ☐ Widowed☐ Other ____________________

Contact Information:

Unless otherwise specified below, by providing phone numbers and emails you are giving permission for Lexington TMS to leave voice mails and contact you via email. For additional information on email communication and privacy, please see our privacy policy.

Cell: *(Default)*_____________________Home:________________Work:________________

Optional: Do Not Leave Voice Mails on the following phone number(s): ________________________

Email Address:____

Please use my email address for: ☐ TMS Clinic Communication ☐For Clinic Updates and Newsletters

Appointment Reminders:

Appointment reminders may be provided by our Electronic Medical Records (EMR) system. When your appointment is scheduled, we will confirm your appointment 2-5 days prior to your appointment time. By completing this section, you acknowledge that information through email/text/voicemail is not necessarily secure, and we cannot guarantee that someone else will not access information regarding your appointment through these means.

☐ I prefer not to receive reminders.

To receive reminders, please check the box that applies:

☐Text or Call or Email ☐Email Only ☐Text Only ☐Call Only ☐Voicemail messages OK

Emergency Contact Information:

Name:____Relationship to Patient: ______________

Phone Number:____________________May we leave messages with this person:

☐Yes ☐No **Additional Contact**

Patient Initials: ______________

Patient Registration Form pg. 2:

Doctor Information:

Primary Care Doctor Name:______________________________Phone:______________

May we contact emergency contact provided regarding your care here? ☐Yes ☐No

Psychiatrist Name:______________________________Phone:______________

May we contact this person regarding your care here? ☐ Yes ☐ No

Therapist/Counselor Name:______________________________Phone:______________

May we contact this person regarding your care here? ☐ Yes ☐ No

Financial Responsibility Agreement:

Lexington TMS reserves the right to charge for services rendered by any practitioner or provider employed by Lexington TMS for all services rendered at our clinic(s).
Please see the different sections below to indicate how payment will be collected and services will be billed. For any questions regarding this section, please contact our Billing Department.

Payments and Billing:

**If you are 18 years of age or older, unless other signatures are provided, statements and financial responsibility will default to you. **

Use of Insurance Plans:

By signing this form, you acknowledge that your insurance coverage, notification of any pre-authorization requirements, and terms of coverage are ultimately your responsibility. You acknowledge that insurance verification checks may not always reflect recent insurance claims, coverage of benefits, or other information. We make every attempt to verify your benefits and obtain pre-authorization and will communicate this to you. If it is not provided or different from what is communicated to us by your insurance provider, you understand that benefit checks and pre- authorization are not a guarantee of payment. Pre-authorization is intended for your benefit and to help ensurepayment from your insurance provider. If pre-authorization is obtained, but your insurance provider rejects services, you may still be responsible for payment of services provided. We make every effort to obtain pre- authorization for services prior to the start of care and will communicate coverage with you. However, insurance changes occur during treatment, and it is your responsibility to notify our office of any changes.

If the **Insurance Holder** is different than that of the Client/Patient receiving services, please providethe information here:

Full Name:______________________________Relationship to Patient:______________

Mailing Address:____

City:______________________State:__________Zip Code:______________

Date of Birth:______/____/__________Employer: ______________________

Patient Initials: __________

Patient Registration Form: pg. 3

Cancellation Policy:

By signing this form, you acknowledge that by scheduling an appointment, we reserve time specifically for you. This time is set aside and prevents others from scheduling during your reservation. We request a minimum of 24hours' notice for any cancellations or reschedules. Because of the time set aside, if proper notice is not given for rescheduling or cancellation, a **cancellation fee of $50.00** will be applied to your account.
Additionally, insurance does not cover missed appointments. Therefore, we allow up to two (3) missed appointments with proper notification as indicated above, **and any appointment missed beyond two will becharged a $50.00 cancellation fee regardless of notification**. Please be aware that a failure to receive a reminder does not waive this cancellation fee. You are still responsible to remember your appointment dates and times.

Special Circumstances:
We make every effort possible to respect the wishes of our clients. However, **Lexington TMS and its affiliates is not responsible for maintaining financial arrangements made between separated or divorced parents or couples under any circumstances.** If there is a financial agreement between such parties, we respect your privacy, and require that you manage those arrangements. For financial responsibility in these types of cases, the person whose signature is on file on the registration paperwork is deemed the party responsible for payment. We cannot acknowledge financial responsibility for a party who is not present to agree to the terms provided. (Statements can be provided to the responsible party, upon request, for proof of payment to other parties).

Past Due Balances:
By signing this document, you acknowledge that unpaid balances of 30 days past due status may be subject to being submitted for collections. If balances are not paid, we reserve the right to utilize collection agency services.Payments are expected at the time of service; however, if a balance is due, it is due within 30 days and may be accepted in person or by mail via cash, credit/debit card or health savings account card. Under no circumstances does Lexington TMS establish payment plans.

Consent to Treatment:
By signing this document, you agree to the following statements:

I agree to participate in treatment and understand that a positive outcome cannot be guaranteed. I understand that positive outcomes are based on my compliance with treatments. I also understand that there are some instances that TMS therapy could worsen my symptoms in certain circumstances, and participation does not guarantee that my symptoms or concerns will be resolved. Lexington TMS assumes that when referred by a physician with a diagnosis of Major Depressive Disorder (MDD) or other diagnosis reimbursed by insurance, that this diagnosis is correct in the Client's/Patients requested medical records and the patient's symptoms are consistent with the diagnosis of MDD or any other insurance reimbursed diagnosis.

Confidentiality and Privacy:
I have read and agreed to the Privacy Notice (HIPAA Statement) provided to me. I understand that I can obtain a printed copy from the staff and can ask for clarification on any policies stated in it.

I (____) have read and understood the above conditions of this document and agree to them. I have asked any questions I am concerned with and understand the policies outlined above.

Patient Signature:____ Date:_____________

Print Name: ____

Patient Registration Form: pg. 4

INSURANCE INFORMATION:

Name of Insurance:____________________ID#:____________________Group#:__________________

Subscribers Name:________________________________Relationship to Patient: ________________

Other Numbers of Insurance Card:___________________Pre-Auth Phone#: ________________________

SECONDARY INSURANCE:

Name of Insurance:__________________ID#:______________________Group#: __________________

Subscribers Name:_____________________________Pre-Auth Phone#: _____________________________

WHO REFERRED YOU FOR TMS THERAPY:

Name of provider who referred you: _____________________ Psychiatrist / Therapist / Primary Doctor

Referral Source Phone#:______________________May we contact: ☐Yes ☐No

Do you have a diagnosis of Major Depression? ☐Yes ☐No

CURRENT PSYCHIATRIC MEDICATIONS

Are you currently taking antidepressant medications: ☐Yes ☐No?

Please list your current medications (*all current psychiatric medications - please answer to the best of your knowledge as information is required to obtain pre-authorization*):

Medication:	Dose:	Start Date	Stop Date	Reason for Discontinuation

Are you currently taking, or have you ever taken any medication for a seizure disorder: ☐Yes ☐No

If so, what medication:______________________Start Date:______________Stop Date: ________________

In the past 6 months, have you used alcohol (ETOH), illicit drugs, or abused benzodiazepines(Klonopin, Xanax, Ativan, etc.): ☐Yes ☐No?

If so, do you drink ETOH on a daily or weekly basis? ☐Yes ☐No How much per_______________day

If you use illicit drugs, which ones: Marijuana / Opiates/ Cocaine / Hallucinogens / Other____________________

If you abuse benzodiazepines, which ones:______________________How many mg per day: ____________

Patient Registration Form: pg. 5

Pre-Authorization Criteria Acknowledgment

FOR TMS THERAPY INSURANCE AUTHORIZATION

For insurance pre-authorization insurance companies typically require the following, which is the minimum requirements for pre-authorization to be submitted:

- A confirmed diagnosis of Major Depressive Disorder or Treatment Resistant Depression, Obsessive Compulsive Disorder (OCD), or Bipolar Depression (BD)
- Prior trials of antidepressant medications with little or no benefit from symptoms OR medication discontinuation due to side effects (each insurance requires a specific number of antidepressant trials - for example, Medicare requires a minimum of two (2) antidepressants with little or no benefit or inability to continue medication due to side effects, other insurances require a history of 3-4 antidepressants during the current episode.
- No history of seizures
- A history of psychotherapy with little or no benefit (physician, therapist, counselor, outpatient mental health visits, etc.
- No TMS Therapy contraindications
- Insurance requires a medical record documentation of all the above, including other qualifying information, to obtain prior authorization for TMS therapy. Lexington TMS will request your medical records from your health care providers to have this information on file for pre-authorization.

Lexington TMS will submit a prior authorization to your insurance upon receipt of all required documentation from you and your current or previous health care providers.

Do you provide permission for Lexington TMS to submit a prior authorization request to your insurance provider for TMS therapy (transcranial magnetic stimulation) services and/or for services tobe provided to you by one of our physicians or healthcare providers? ☐Yes ☐No

I have read or have been made aware of the following:

- HIPPA Notice and Patient Privacy Acts
- TMS Therapy Contraindications
- TMS Therapy Hearing Protection Waiver
- Indications for and any side effects of TMS Therapy, including an explanation of TMS Therapy for the treatment of major depression or other diagnosis that I may be receiving TMS Therapy for.
- I have had all my questions and/or concerns answered

I also understand that TMS therapy treatment sessions emit a loud ticking noise, like that of magnetic resonance imaging (MRI). There has been no reported history of hearing loss; however, earplugs are available and recommended for me to wear during each treatment session. I understand I may elect to decline wearing the ear plugs. I also agree to hold Lexington TMS and each of its employees and physicians harmless from any liability related to any hearing problems during or after my treatment regardless of whether I elect to where or decline to wear earplugs (i.e., hard of hearing, hearing loss, or any other hearing-related problem.)

A parent signature is required for all patients under the age of 18. A guardian signature is required if patient has a guardian.

Patient Signature:______________________________ Date:____________________

Print Name:______________________________

Parent/Guardian Signature:______________________________ Date:____________________

Parent/Guardian Printed Name:______________________________

Client Initials:__________

Patient Registration Form: pg. 6

TMS Prior Authorization Information

Have you ever been diagnosed with bipolar disorder? ☐Yes ☐No OCD? ☐Yes ☐No
Schizophrenia? ☐Yes ☐No Substance Use Disorder? ☐Yes ☐No PTSD? ☐Yes ☐ No
Eating Disorder? ☐Yes ☐No Seizure Disorder? ☐Yes ☐No
Any other Neurological Disorder (dementia, Alzheimer's, stroke, autism, epilepsy)? ☐Yes ☐No

Onset of symptoms: ☐ loss of hope ☐ low self-esteem ☐ insomnia ☐ appetite changes
☐ sadness ☐ loss of interest ☐ decreased motivation ☐ irritability
☐ feeling down ☐ anxiousness ☐ sleeping too much ☐ lack of social activity

Current symptoms: ☐ increase in sadness ☐ sleeping too much ☐ increased irritability
☐ missed work ☐ over-eating ☐ increased loss of appetite ☐ crying spells
☐ no motivation ☐ social isolation

Do you have current thoughts of: ☐ self-harm ☐ suicide ☐ thoughts to harm someone else

Have you participated in outpatient therapy? ☐Yes ☐No
If so, where:________________________ When (estimate if needed):__mo_____yr How long: ________

Do you have a therapist or counselor? ☐Yes ☐No If so, who? ________________________

Have you been hospitalized for depression in the past? ☐Yes ☐No Hospital: ____________________
If so, what was the approximate date:________________________(month / year)

Have you had any of the following in the past: ☐ TMS ☐ ECT ☐ Vagus Nerve Stimulator

Do you currently have a Vagus Nerve Stimulator? ☐Yes ☐No

If you have had TMS before, please let us know where?________________________State ______
(Please be sure to add TMS provider to your Release of Medical Records as this information will be required to obtain your prior authorization)

Do you have any ferromagnetic or other magnetic-sensitive metals implanted in your head or within 30cm of your head? ☐Yes ☐No

Are you currently pregnant? ☐Yes ☐No If yes, are you nursing? ☐Yes ☐No

What types of psychotherapy have you tried in the past or are you currently in? ☐ N/A

Please check all previous types of psychotherapy:
☐ Therapist/Counselor ☐Cognitive Behavioral Therapy (CBT) ☐Client Centered Therapy (CCT/PCT)
☐ Existential Therapy ☐ Dialectical Behavioral Therapy (DBT) ☐ Dialectical Behavioral Therapy (DBT)
☐Psychoanalytic or Psychodynamic Therapy (exploration of unconscious thoughts)
☐ Interpersonal Psychotherapy (IPT) ☐ Mindfulness Therapy ☐Group Therapy
☐ Extended visits with psychiatrist ☐Other Therapy: ____________________

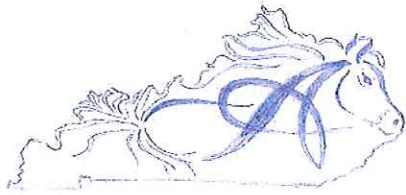
At what age were you initially diagnosed with depression (estimate): Age: ________

Have you ever been in remission from depression? ☐Yes ☐No If so, during what time frame? __________

I,____________________attest that I have completed the above assessment and that the information provided is true and accurate to the best of my knowledge. I authorize Lexington TMS, LLC to submit a pre- authorization request to my insurance based on the above information and my requested medical records if necessary.

Patient Signature:________________________Date: ____________

Patient Printed Name: ________________________



Lexington TMS Therapy Medication Checklist

Below is a list of common medications that are used to treat depression. Please mark the medications you have been prescribed **in the past** or **are currently prescribed.** We will likely need to obtain a prior authorization from your insurance, and this information will be required. Provide estimated dates of use and the reasons for discontinuing. Please bring this medication checklist with you at the time of your appointment.

SSRI (Selective Serotonin Re-uptake Inhibitors) Medications

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing (Side Effects)
citalopram	Celexa	O 20mg O 40mg		
escitalopram	Lexapro	O 10mg O 20mg		
fluoxetine	Prozac	O 20mg O 40mg O 60mg		
fluvoxamine	Luvox	O 100mg O 200mg O 300mg O Other		
fluvoxamine CR	Luvox CR	O 100mg O 200mg O 300mg O Other		
paroxetine	Paxil	O 20mg O 40mg O 60mg O Other _______		
paroxetine CR	Paxil CR	O 12.5mg O 25mg O 50mg O 62.5mg		
sertraline	Zoloft	O 50mg O 100mg O 200mg O Other		
vortioxetine	Trintellix	O 5mg O 10mg O 20mg		
vilazodone	Viibryd	O 20mg O 40mg		

SNRI (Serotonin-Norepinephrine Reuptake Inhibitors)

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing
desvenlafaxine	Pristiq	O 50mg O 100mg		
duloxetine	Cymbalta	O 60mg O 90mg O 120mg		
venlafaxine	Effexor	O 150mg O 200mg O 225mg O Other		
venlafaxine XR	Effexor XR	O 75mg O 150mg O 225mg O 300mg		
levomilnacipran	Fetzima	O 40mg O 80mg O 100mg O Other		
milnacipran	Savella	O 50mg O 100mg		

TCA (Tricyclic Antidepressants)

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing
amitriptyline	Elavil	O 50mg O 100mg O 150mg O Other ____		
clomipramine	Anafranil			
desipramine	Norpramin	O 100mg O 200mg		
doxepin	Sinequan			
imipramine	Tofranil	O 50mg O 100mg O 150mg O Other		
maprotiline	Ludiomil			
nortriptyline	Pamelor	O 100mg O 150mg O Other		
trimipramine	Surmontil	O 50mg O 100mg O 150mg O Other		
protriptyline	Vivadil / Vivactil	O 40mg O 60mg		

NDRI (Norepinephrine-Dopamine Reuptake Inhibitors) / Atypical Antidepressants

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing
bupropion	Wellbutrin	O 300mg O Other ______		
bupropion XL	Wellbutrin XL	O 150mg O 300mg O 450mg		
bupropion SR	Wellbutrin SR	O 100mg O 150mg O Other_______		
mirtazapine	Remeron	O 15mg O 30mg O 45mg O 60mg		
nefazodone	Serzone			

MAOI (Monoamine Oxidase Inhibitors)

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing
phenelzine	Nardil	O 60mg O 80mg O 90mg O Other ______		
selegiline	Emsam	O 6mg O 12mg		
tranylcypromine	Parnate	O 30mg O 50mg O 60mg O Other		

SARI (Serotonin Antagonist and Reuptake Inhibitor)

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing
desyrel	Trazodone	O 150mg O 200mg O 400mg O Other _____		
vortioxetine	Trintellix	O 10mg O 20mg		
nefazodone	Serzone	O 300mg O 400mg O 600mg O Other		

MOOD STABILIZERS

Generic Name	Brand Name	Dose	Est. Length of Use	Reason for Discontinuing
aripiprazole	Abilify	O 2mg O 5mg O 10mg O 15mg O 20mg O 30mg		
eskalith	Lithium	O 600mg O 800mg O 1000mg O 1200mg O 1500mg O Other _____		
carbamazepine	Tegretol	O 600mg O 800mg O 1000mg O 1200mg O 1600mg O Other _____		
carbamazepine XR	Equettro	O 600mg O 800mg O 1000mg O 1200mg O 1600mg O Other _____		
divalproex	Depakote	O 750mg O 1500mg O Other		
lamotrigine	Lamictal	O 50mg O 100mg O 200mg O 300mg O 400mg O 500mg O Other _______		
brexpiprazole	Rexulti	O 1mg O 2mg O 3mg O 4mg		
oxcarbazepine	Trileptal	O 1200mg O 2400mg O Other		
aripiprazole	Abilify	O 2.5mg O 5mg O 7.5mg O 10mg		
quetiapine	Seroquel	O 25mg O 50mg O 100mg O 200mg O 300mg O 400mg O 500mg O 500mg O 600mg O Other _____		
lurasidone HCL	Latuda	O 40mg O 60mg O 80mg		
olanzapine	Zyprexa	O 5mg O 7.5mg O 10mg O 20mg		
ziprasidone	Geodon	O 40mg O 80mg O 120mg		
asenapine	Saphris	O 5mg O 10mg O Other		

Lexington TMS

Timothy Allen, M.D.
American Board of Psychiatry and Neurology
Board Certified in General Psychiatry
Board Certified in Forensic Psychiatry
Board Certified in Brain Injury Medicine
Distinguished Fellow of the American Psychiatric Association

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1401 Harrodsburg Rd, Suite B488
Lexington, KY 40504
Phone: (859) 277-7423
FAX: (859) 278-9256
Tsamd.scheduling@gmail.com
LexingtonTMS.com

Patient Full Name: ______________________________ Date: ______________

TMS THERAPY EXCLUSION CRITERIA

TMS therapy is contraindicated for use in some situations as identified below. The TMS therapy system treatment coil produces strong, pulsed magnetic fields, which can affect certain implanted devices or objects. The magnetic field strength diminishes quickly with increasing distance from the coil. Within 30 cm of the face of the treatment coil, the peak magnetic field can be greater than 5 Gauss, which is the recommended static magnetic field exclusion level for many electronic devices.

TMS therapy is contraindicated for use in patients who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm of the treatment coil.

Removable objects that may be affected by the magnetic field should be removed before treatment to prevent possible injury. (Examples include jewelry/hair barrettes, etc.). Once these objects are removed TMS is not contraindicated for these patients.

Please complete the following form prior to the start of TMS treatment. If you have selected any of the boxes under the contraindicated section, then TMS therapy is contraindicated, and therefore would not be a viable treatment option.

Permanent tattoos or make-up, permanent mouth retainers, braces, and any other types of metal within or near the head that are not listed as a known TMS contraindication. However, there has not been significant research to specifically indicate whether transcranial magnetic stimulation (TMS) will cause any adverse reaction or event or side effect for any situation or circumstance that is NOT listed on our Contraindication Form.

By signing below, you acknowledge and agree that you do not have any of the confirmed contraindications indicated on the TMS therapy Contraindications Form. There is still a potential for a negative reaction, side effect, or adverse outcome from other items listed above; and you agree to continue with TMS therapy treatment and hold Lexington TMS and any of its employees or affiliates harmless of any adverse outcome, event, or side effect that may occur as a result of receiving TMS therapy.

Patient Initials: ___________

Patient Printed Name:______________________________ Date: __________

Patient Signature: ______________________________

Witness:______________________________ Date: __________

CONFIRMED CONTRAINDICATIONS FOR TMS THERAPY

Please check any of the below that applies to you

- ☐ Cochlear implants
- ☐ Implanted electrodes/simulators
- ☐ Aneurysm clips/coils
- ☐ Stents
- ☐ Device leads
- ☐ Deep brain stimulator
- ☐ Vagus nerve stimulators
- ☐ Pacemaker
- ☐ Implanted Cardioverter Defibrillator (ICD)
- ☐ Wearable Cardioverter Defibrillator
- ☐ Previously removed ICD
- ☐ Magnetically activated dental implants
- ☐ Ferromagnetic ocular implants
- ☐ Cerebral Spinal Fluid Shunt
- ☐ Pellets, bullets, fragments (30cm from coil)
- ☐ Facial tattoos w/metallic ink
- ☐ EEG electrodes
- ☐ DBS electrodes
- ☐ Metallic devices implanted in head

>30cm from Head

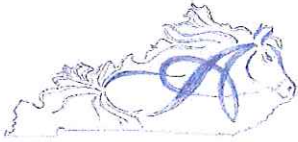
- ☐ Infusion pump
- ☐ Implanted insulin pump
- ☐ Stents, filters, heart valves
- ☐ Magnetically programmable shunt valves
- ☐ Cervical fixation devices
- ☐ Staples, sutures
- ☐ Radioactive seeds
- ☐ Verichip microtransponder

Remove from Patient

- ☐ Holter monitor
- ☐ Bone growth stimulators
- ☐ Portable glucose monitor
- ☐ Hearing aids
- ☐ Eyeglasses
- ☐ Cell phone
- ☐ Headphones/MP3 players
- ☐ Staples, sutures
- ☐ Radioactive seeds
- ☐ Cervical fixation device

If you have checked any of the above, then TMS therapy is contraindicated as a treatment option and is not recommended as a safe treatment for you.

Patient Initials: __



Lexington TMS

Patient Consent for
Transcranial Magnetic Stimulation (TMS Therapy)

This is a patient consent for a medical procedure called TMS therapy. This consent form outlines the treatment that the doctor has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you, and any alternative treatments that are available for you if you decide not to be treated with TMS therapy.

The information contained in this consent form is also communicated with you during your initial consultation visit. We encourage you to ask any questions that you may have regarding TMS that may not have been addressed or clarified during your TMS Consultation visit.

The following information has been explained to me:

a. TMS stands for "Transcranial Magnetic Stimulation". TMS therapy is a medical procedure. A TMS treatment session provides electrical energy to a "treatment coil" or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines.

b. TMS is an FDA-approved treatment for patients with depression who have not benefited from antidepressant medications and is considered safe and effective.

c. Specifically, TMS therapy has been shown to relieve depression symptoms in adult patients who have failed to receive satisfactory improvement from prior antidepressant medication in the current episode.

d. During a TMS treatment session, the doctor or a member of their staff will place the magnetic coil gently against my scalp. The magnetic fields that are produced by themagnetic coil are pointed at a region of the brain being treated. To administer the treatment, the doctor or a member of their staff will first position my head appropriately. Once treatment begins, I will hear a clicking sound and feel a tapping sensation on my scalp. The device will be adjusted by the doctor and will give just enough energy to send electromagnetic pulses into my brain so that my right hand twitches. The amount of energy required to make my hand twitch is called the "motor threshold". Every patient has a different motor threshold and the

treatments are given at an energy level that is just above my individual motor threshold. How often my motor threshold will be re-evaluated will be determined by my doctor and depends on my initial response to the treatment.

e. Once motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses". Treatment will take about 3-20 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. For optimal results, my doctor will determine the best and most appropriate treatment protocol for my condition and circumstance. For example, a standard depression treatment requires 5 treatments per week for 4 to 6 weeks with the last 6 sessions tapered over 3-weeks (up to 36 treatments) lasting approximately 20 minutes per treatment.

f. During the treatment, I may experience a tapping sensation at the treatment site while the magnetic coil is turned on. I understand this '*tapping*' may be uncomfortable for me, and for some people, may be perceived as painful. I understand that I should inform the doctor or his/her staff if unable to tolerate the '*tapping*'. The doctor or technician may then adjust the dose or make changes to where the coil is placed to help make the procedure more comfortable for me. I also understand that I may experience a headache after treatment. I understand that both discomfort and headaches are a potential side effect but often lessen over time. I may take an over-the-counter medication if a headache occurs.

g. TMS therapy should not be used by anyone who has:

1) Magnetic-sensitive metal in their head or within 12 inches (30 cm) of the magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. These include but are not limited to:
2) Cochlear implants
3) Aneurysm clips or coils
4) Stents
5) Electrodes to monitor your brain activity
6) Ferromagnetic implants in your ears or eyes
7) Bullet fragments
8) Other metal devices or objects implanted in the head
9) Facial tattoos with metal ink or permanent makeup
10) Implanted stimulators in or near the head. These may include:

    a Deep brain stimulator, b. Cochlear implant, c. Vagus Nerve stimulator

h. The TMS system should be used with caution in patients who have pacemakers or implantablecardioverter defibrillators (or are using wearable cardioverter defibrillators (WCD). **Failure to follow this restriction could result in serious injury or death.**

i. TMS therapy 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. It is important to note that during the first 2-weeks (especially over the firstcouple weekends - Saturday/Sunday) you may feel '*more down than usual*' as the treatment begins to work.

j. While very rare, seizures have been reported with the use of TMS devices. The estimated risk of seizure under ordinary clinical use is approximately 1 in 30,000 treatments or 1 in 1000 patients.

k. Because the TMS therapy system produces a loud click with each magnetic pulse, I understand that I should wear earplugs with a rating of 30dB or higher or sign a waiver to decline hearing protection devices during treatment.

l. 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. Some patients do not respond until up to 2-weeks following the final treatment session.

m. I understand that symptom relief from TMS therapy may be lost over time, and I may need to take antidepressant medication to help retain symptom relief. I understand that approximately one-third of patients require re-treatment TMS therapy in approximately six to eighteen months, as I acknowledge that every patient responds differently. New research indicates that periodic maintenance treatments or annual treatments optimizes symptom relief, and thus offers longer remission periods from depression.

n. I understand that I may discontinue treatment at any time.

o. **For Women Only:** I understand that I may not consent to this treatment if there is any chance that I may be pregnant. I understand that I may be asked to have a pregnancy test prior to initiation of TMS and that, if the results are positive, I may not be allowed to have the treatment. If I am pregnant and desire to proceed with the treatment, I will take sole responsibility for providing a release from my Obstetrician or Gynecologist to have the treatment as necessary in view of the risks to both myself and my unborn child. If I become pregnant during the course of TMS, I agree to inform Dr. Allen of my condition as soon as I know of it. I will accept full responsibility for failure to inform Dr. Allen of my condition, including any and all outcomes of my pregnancy. I agree to take all appropriate birth control measures to prevent becoming pregnant during the course of my treatment.

I understand that Lexington TMS will maintain strict COVID-19 policies and procedures and understand that if I have any questions related to this policy or regarding possible COVID-19 symptoms, I may call the office for clarification.

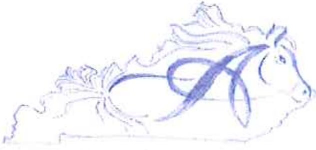
I have read the information contained in this Medical Procedure Consent Form about TMS therapy and its potential side effects and/or risks. I have all my questions answered. I understand there are other treatment options for my depression available to me, such as medications and psychotherapy and this has also been discussed with me.

I therefore permit Dr. Allen and his/her TMS Therapy staff to administer TMS therapy treatment to me.

PATIENT NAME (PRINTED) DATE

PATIENT SIGNATURE

WITNESS (TMS EMPLOYEE) DATE



Lexington TMS

Timothy Allen, M.D.
American Board of Psychiatry and Neurology
Board Certified in General Psychiatry
Board Certified in Forensic Psychiatry
Board Certified in Brain Injury Medicine
Distinguished Fellow of the American Psychiatric Association

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Tsamd.scheduling@gmail.com
LexingtonTMS.com

NOTICE

The privacy of your health information is important to us. We will maintain the privacy of your health information and will not disclose your information to others without your permission, or unless the law authorizes or requires us to do so.

The federal law HIPAA requires that we take additional steps to keep you informed about how we may use the information gathered to provide health care services to you. As part of this process, we are required to provide you with a Notice of Privacy Practices and to request that you sign a written acknowledgment that you received a copy of our Notice of Privacy Practices.

The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, or payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights regarding health information that we maintain about you, and a brief description of how you may exercise your rights.

If you have any questions about this notice, please contact
Lexington TMS
859-277-7423

What is Protected Health Information?

Protected Health Information is information that relates to:
(1) Your past, present or future physical or mental health or condition;
(2) The provision of health care including mental health care to you;
(3) The past, present, or future payment for the provision of health care including mentalhealth care to you; and includes
(4) Demographic information that identifies you or that could be used to identify you.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice, which may be amended from time to time.

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in Section II G of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

a. **Permissible Uses and Disclosures Without Your Written Authorization** – We may use and disclose PHI without your written authorization, excluding Psychotherapy Notes asdescribed in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

i. **Payment:** We may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. For example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

ii. **Health Care Operations:** We may use or disclose PHI in connection with my health care operations, including quality improvement activities, training programs, accreditation, certification, licensing, or credentialing activities.

iii. **Communications:** We may use or disclose PHI to contact you regarding missed appointments or if we need to change our appointment time. We may leave messages on your answering machine unless you have directed me otherwise. When we communicate by cell phone or computer, be aware that the information isnot always secure from access by third parties.

iv. **Treatment:** We may use PHI to diagnose and treat you. We may use PHI to inform you about treatment alternatives or other related topics. We may also use ordisclose PHI for clinical coverage during periods of my absence.

v. **Required or Permitted by Law:** We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to

your health or safety or the health of safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or others as authorized by law.

b. Uses and Disclosures Requiring Your Written Authorization

1. **TMS Therapy:** Notes recorded by our clinician(s) documenting the contents of a treatment session withyou during TMS therapy treatment will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. **Treatment:** We will not use or disclose PHI to other health providers without your written consent.

3. **Marketing Communications:** We will not use your health information for marketing communications without your written authorization.

4. **Other Uses and Disclosures:** Uses and disclosures other than those described inSection I A above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

c. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

b. **Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

c. **Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to such restriction you may request.

d. **Right to Accounting Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us. This right applies to disclosures for purposes other than treatment, payment, or health care operations and excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

e. **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

f. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time at address indicated below.

g. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact Lexington TMS at the address and contact information indicated on page 1 of this notice. You may also file written complaints with the Director, Office for Civil Rights of the United States Department of Health and Human Services. We will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. Effective Date. This Notice is effective immediately.

b. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing thenew notice. If we change this Notice, we will post the revised notice in the waiting area of our office. You may also obtain any revised notice by contacting the Privacy Officer.

Lexington TMS

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

By my signature, I_______________________________________, acknowledge that I received a copy of the Notice of Privacy Practices for Lexington TMS.

____ ___________________________

Signature of Client (or personal representative) Date

If this acknowledgement is signed by a guardian, or personal representative of the client, please complete the following:

Personal Representative's Name: ____

Relationship to the Client: ____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledge of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented obtaining the acknowledgement
_____Other (please explain)

____

Signature Date

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD

Client Name: (Include Middle Init) ______________________________ Date: ____________

Beck Depression Inventory

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully. And then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

THE PSYCHOLOGICAL CORPORATION
Harcourt Brace & Company
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_________ Subtotal Page 1

THERAPIST WILL SCORE

Client Initials: ________ Date: ____________

11. Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated, it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness
0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to others.
3 I feel utterly worthless.

15. Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
0 I have not experienced any change in my sleeping.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
0 I am not more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite
0 I have not experienced any change in my Appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty
0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue
0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

__________ Subtotal Page 2
__________ Subtotal Page 1
__________ TOTAL SCORE

THERAPIST WILL SCORE

AUTHORIZATION FOR RELEASE OF INFORMATION

LEXINGTON TMS PLLC
1401 Harrodsburg Road, Ste. B-488
Lexington, KY 40504-3795
Phone: 859-277-7423 Fax: 859-278-9256

____
Date:

______________________________ ____
Name of Patient Address

______________________________ ____
Date of Birth City, State, Zip Code

______________________________ ____
Social Security Number Phone Number

I hereby authorize (*your doctor*) ____

____
Your doctors address/phone number here

to furnish information relative to my hospitalization and/or treatment rendered during the period

from ____________________ to __________________ to the following:

Mail or fax records to: Lexington TMS PLLC
1401 Harrodsburg Rd, Ste. B-488
Lexington, KY 40504
Fax: 859-278-9256

Information requested:

_______ Diagnosis

_______ Treatment

_______ Prognosis

_______ Recommendations

_______ Psychological Testing

_______ Psychological History

____
Signature of Patient

____
Signature of next of kin, if patient is a minor, mentally incompetent or deceased

____
Relationship to Patient

____
Address of Next of Kin

____
Witness