ACHIEVE TMS | EAST
Featuring Brainsway dTMS

Preferred Treatment Site	
❑ Amherst	❑ Plymouth
❑ Andover	❑ Springfield
❑ Chelmsford	❑ West Hartford, CT
❑ Glastonbury, CT	❑ Westborough
❑ Leominster	❑ Weymouth
❑ Natick	❑ Woburn
❑ Newburyport	❑ Worcester
❑ Northampton	

TMS PRE-AUTHORIZATION QUESTIONS

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ CITY/ZIP: _____

PHONE NUMBER: _____ ☐Cell ☐Home Race/Ethnicity: _____

EMAIL: _____ CONTACTED BY EMAIL? ☐ YES ☐ NO

REFERRED BY: _____

TMS TECHNICIAN: _____ DATE OF CONSULT: _____

1. Please describe your symptoms of your current episode of depression and approximately how long you have felt them: _____

2. Please list CURRENT Psychiatrist and how long you've been seeing them: _____

Therapists: _____
Primary Care Provider: _____

☐ If no CURRENT provider please provide name, title, and approximate time of last seen provider: _____

3. Do you have a history of substance use? Y ☐ N ☐ If yes, when and what substance? _____

4. What other types of treatment have you tried for your depression (Check all that apply)?

☐ INDIVIDUAL COUNSELING
☐ GROUP THERAPY
☐ FAMILY THERAPY
☐ COUPLES THERAPY
☐ COGNITIVE BEHAVIORAL THERAPY (CBT)
☐ ELECTROCONVULSIVE THERAPY (ECT)
☐ INTENSIVE OUTPATIENT
☐ PARTIAL HOSPITALIZATION
☐ INPATIENT HOSPITALIZATION
☐ EMDR
☐ DIALECTICAL BEHAVIORAL THERAPY (DBT)
☐ TRANSCRANIAL MAGNETIC STIMULATION (TMS)

5. Please list ALL your CURRENT medications & supplements (not just those prescribed for depression), including doses.

MEDICATIONS	DOSE	WHAT IT TREATS	DATE STARTED

6. What Medications have you tried in the PAST? What was your response to, and side effects from these medications?

Medication	Date Started	Date Ended	Dosage	Side Effect/Response
Prozac (fluoxetine)				
Zoloft (sertraline)				
Paxil (Paroxetine)				
Celexa (Citalopram)				
Lexapro (Escitalopram)				
Luvox (fluvoxamine)				
Effexor (venlafaxine)				
Pristiq (desvenlafaxine)				
Cymbalta (duloxetine)				
Viibryd (vilazodone)				
Trintellix (vortioxetine)				
Wellbutrin (bupropion)				
Remeron (mirtazapine)				
Serzone (nefazodone)				
Desyrel (trazodone)				
Lamictal (lamotrigine)				
Lithium				
Risperdal (risperidone)				
Seroquel (quetiapine)				
Geodon (ziprasidone)				
Abilify (aripiprazole)				
Rexulti (brexpiprazole)				
Pamelor (nortriptyline)				
Elavil (amitriptyline)				
Norpramin(desipramine)				
Tofranil (imipramine)				
Anafranil (clomipramine)				
Vivactyl (protriptyline)				
Emsam Patch (Selegiline)				
MAOIs				
Deplin (L-methylfolate)				
Stimulants for depression (Adderall, Ritalin)				
Other				

AUTHORIZATION FOR RELEASE OF INFORMATION

_____

Print Name of Client Date of Birth

I hereby authorize **Achieve TMS Centers East, P.C.**, to exchange information with:
Name of Agency/Person/Organization: _____
Address: _____
City, State, ZIP Code: _____
Phone No: _____ **Fax No:** _____
With the knowledge that such contact discloses the fact that mental health services have been/are being provided.
This disclosure of information is required for the following purpose(s):

□ Evaluation □ Treatment Planning/Course
□ Coordination of care □ Other_____

And will consist of the following types of information:

□ Verbal communication
□ Entire Record □ Dates/Results of medical assessments & Diagnoses
□ Medication History □ Results of psychological testing
□ Discharge Summary □ Treatment Plan
□ Legal Information □ Other:_____

The information and records released pursuant to this consent will not be used for any other purpose.

This consent becomes effective immediately. This consent may be revoked by the undersigned at any time. If not revoked, it shall terminate one year from the signed date below**.** I understand that I may receive a copy of this authorization. There is a risk that the person receiving information or documents pursuant to this authorization may re- disclose the information and documents in a manner that will no longer provide protection for the information and documents.

_____ Date:_____
Signature of Client

_____ Date: _____
Signature of Parent, Guardian or Conservator

_____

I understand that if I have any health information in my medical record related to substance abuse treatment or HIV/AIDS, it is protected under federal regulations (US 42 CFR Part 2) and cannot be disclosed without my written authorization unless otherwise provided for in the federal regulations. I hereby authorize **Achieve TMS Centers East, P.C. to exchange this protected health information with the above listed provider(s).

_____ Date:_____
Signature of Client

□ All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

AUTHORIZATION FOR RELEASE OF INFORMATION

_____

Print Name of Client Date of Birth

I hereby authorize **Achieve TMS Centers East, P.C.**, to exchange information with: **MY PHARMACY**
Name of Agency/Person/Organization: _____
Address: _____
City, State, ZIP Code: _____
Phone No: _____ **Fax No:** _____
With the knowledge that such contact discloses the fact that mental health services have been/are being provided.
This disclosure of information is required for the following purpose(s):

□ Evaluation □ Treatment Planning/Course
□ Coordination of care □ Other_____

And will consist of the following types of information:

□ Verbal communication
□ Entire Record □ Dates/Results of medical assessments & Diagnoses
□ Medication History □ Results of psychological testing
□ Discharge Summary □ Treatment Plan
□ Legal Information □ Other:_____

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Signature of Client

_____ Date: _____
Signature of Parent, Guardian or Conservator

_____

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_____ Date:_____
Signature of Client

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AUTHORIZATION FOR RELEASE OF INFORMATION

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Print Name of Client Date of Birth

I hereby authorize **Achieve TMS Centers East, P.C.**, to exchange information with: **MY PSYCHIATRIST**
Name of Agency/Person/Organization: _____
Address: _____
City, State, ZIP Code: _____
Phone No: _____ **Fax No:** _____
With the knowledge that such contact discloses the fact that mental health services have been/are being provided.
This disclosure of information is required for the following purpose(s):

□ Evaluation □ Treatment Planning/Course
□ Coordination of care □ Other_____

And will consist of the following types of information:

□ Verbal communication
□ Entire Record □ Dates/Results of medical assessments & Diagnoses
□ Medication History □ Results of psychological testing
□ Discharge Summary □ Treatment Plan
□ Legal Information □ Other:_____

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_____ Date:_____
Signature of Client

_____ Date: _____
Signature of Parent, Guardian or Conservator

_____

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_____ Date:_____
Signature of Client

□ All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

AUTHORIZATION FOR RELEASE OF INFORMATION

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Print Name of Client Date of Birth

I hereby authorize **Achieve TMS Centers East, P.C.**, to exchange information with: **MY THERAPIST**
Name of Agency/Person/Organization: _____
Address: _____
City, State, ZIP Code: _____
Phone No: _____ **Fax No:** _____
With the knowledge that such contact discloses the fact that mental health services have been/are being provided.
This disclosure of information is required for the following purpose(s):

□ Evaluation □ Treatment Planning/Course
□ Coordination of care □ Other_____

And will consist of the following types of information:

□ Verbal communication
□ Entire Record □ Dates/Results of medical assessments & Diagnoses
□ Medication History □ Results of psychological testing
□ Discharge Summary □ Treatment Plan
□ Legal Information □ Other:_____

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_____ Date:_____
Signature of Client

_____ Date: _____
Signature of Parent, Guardian or Conservator

_____

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_____ Date:_____
Signature of Client

□ All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

AUTHORIZATION FOR RELEASE OF INFORMATION

_____

Print Name of Client Date of Birth

I hereby authorize **Achieve TMS Centers East, P.C.**, to exchange information with: **MY PRIMARY CARE PHYSICIAN**
Name of Agency/Person/Organization: _____
Address: _____
City, State, ZIP Code: _____
Phone No: _____ **Fax No:** _____
With the knowledge that such contact discloses the fact that mental health services have been/are being provided.
This disclosure of information is required for the following purpose(s):

□ Evaluation □ Treatment Planning/Course
□ Coordination of care □ Other_____

And will consist of the following types of information:

□ Verbal communication
□ Entire Record □ Dates/Results of medical assessments & Diagnoses
□ Medication History □ Results of psychological testing
□ Discharge Summary □ Treatment Plan
□ Legal Information □ Other:_____

The information and records released pursuant to this consent will not be used for any other purpose.

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_____ Date:_____
Signature of Client

_____ Date: _____
Signature of Parent, Guardian or Conservator

_____

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_____ Date:_____
Signature of Client

□ All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

HIPAA NOTICE OF PRIVACY PRACTICES

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what our Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

We may use and share personal health information that is protected (PHI) to you or your personal representative. We may use and share this information:

- For healthcare treatment that doctors, nurses and other clinicians give you
- For certain business activities called "health care operations" and For payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

- To report abuse, neglect, or domestic violence
- To prevent a serious threat to your other's health or safety
- To prevent public health problems
- To agencies that audit, investigate and inspect health programs for the public's health for lawsuits and other legal proceedings for research
- To the Government for specialized purposes, such as military or national security; and
- For worker's compensation.

YOUR RIGHTS

You have the following rights as described in our Notice:

- The right to ask us if we will put more limits on the way we use and share PHI about you
- The right to share confidential communications from us
- The right to see and get a copy of PHI about you
- The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference http://www.hhs.gov/ocr/privacy.

I hereby acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices.

PATIENT (PRINT): _____

SIGNATURE: _____ DATE: _____

FOR PATIENTS UNDER THE AGE OF 18:

RESPONSIBLE PARTY (PRINT): _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

I hereby acknowledge that I received a copy of the "Patient Rights & Responsibilities" document: _____ Initials

Northampton site 47 Pleasant Street, Suite #1-NW 413-203-6922