Pelorus TMS

_____
Patient Last Name

Office Policies and Treatment Consent

Welcome to our Pelorus TMS, specializing primarily in major depression treatment for those who have not responded to multiple anti-depressant medication trials. We thought it would be helpful to spell out some details, to avoid any confusion. Our goal is to help you (or your loved one) feel better, while realizing that no honest person can predict the future or guarantee an outcome. To work together successfully, we need some guidelines:

1. **SCOPE OF PRACTICE/SERVICES:**
   Dr. Matthew Barnas is the Medical Director of Pelorus Elder & Behavioral Health, and is Board Certified in Geriatric and Adult Psychiatry. He assists individuals with issues like memory loss, anxiety, insomnia, depression, weight loss, ADD, paranoia, delusions, hallucinations, impulsivity, and dementia with behavioral disturbances. He has experience treating individuals in hospital-based, residential, and office-based settings. Dr. Barnas is also a certified TMS provider.
   In addition, there are other excellent and highly-trained TMS professionals within the Pelorus TMS group including Psychiatrist Dr. Deborah Ocasio and our certified TMS Coordinators, who will **also** be involved in providing care to you or your loved one. (The specifics will depend upon which of our two office locations at which you receive care). While Dr. Barnas or Dr. Ocasio will often personally conduct the first evaluation, the trained TMS Coordinator or another TMS trained team member will perform ongoing TMS treatments under the delegation of the attending physician.
   For more information about our team of clinicians, please visit our website: http://pelorustms.com/team/

2. **CANCELLATION AND NO SHOW POLICY:**
   As a Medicare-accepting and uniquely specialized TMS practice, we are very highly in-demand. Therefore, our available time for office consultations and TMS treatments are limited. If you have scheduled an appointment, please do try to keep it. If it's necessary to miss your appointment, we require advance notice, allowing us to assist someone else in need. **We require at least 24 business hours notice to cancel your appointment or TMS session**. If your appointment is on a Monday, we must be notified by the same hour on the preceding Friday.
   If you do not give **at least 24 business hours** advance notice for a missed appointment, you (or your guardian) will be charged $250 for missed TMS treatments. Charges are based on appointment type. We will occasionally make an exception in extreme circumstances. If there was a charge made for a no-show or a missed appointment, we do expect you pay that fee in order to schedule a follow-up, as that is your responsibility, as insurance does not cover missed appointment.

14 Ridgedale Ave.
Suite 103
Cedar Knolls, NJ
07927

P: 973- 295-6335
F: 862-345-9037

All Correspondences

www.pelorusTMS.com

575 Route 28
Building 2, Suite 2108
Raritan, NJ
08869

P: 908-722-4122
F: 862-345-9037

3. **COMMUNICATION:**

Dr. Barnas and his staff can be reached at the central office number: 973-295-6335. The office team is staffed Monday through Friday from 9:00 AM to 5:00 PM. During business hours, if you are routed to our secure voice mail, it means our team is occupied assisting other patients, and *you should kindly leave us a detailed message in order for us to follow up with you as efficiently as possible*. Non-urgent calls are usually returned within the same day, but at the latest, by the end of the following business day.

After business hours, if you are calling with a non-urgent message, press "1" and leave your message. **Issues like "appointment questions" are not emergencies, and should be left in mailbox "1".** The office is **not** staffed on weekends or holidays.

If you are calling with a very serious, emergency situation, press "5" and leave your message there. This emergency line is monitored 24 hours/day, 7 days/week. Your message will go directly to our provider that is on duty covering emergency calls.

******In the rare instance that you call us with an urgent emergency situation, and you do not receive a prompt return call, then IMMEDIATELY GO STRAIGHT TO THE NEAREST EMERGENCY ROOM, or CALL 911 for EMS ASSISTANCE. The ER staff will contact us, while you are safely under the hospital's care and supervision.******

4. **EMAIL:**

Be aware that email is not a confidential means of communication. We also cannot guarantee that email messages will be received or responded to in a timely fashion. As such, **email is not an appropriate way to communicate very urgent or confidential information**. Dr. Barnas and our medical providers do not email with patients or family, although our administrative office team will email with patients for non-urgent issues like appointment scheduling.

5. **"PRIOR AUTHORIZATIONS" and "DEDUCTIBLES":**

Some insurance policies may require a "Prior Authorization" before covering the costs of treatment. Or, your plan may involve a minimum "Deductible" payment every year. You are responsible for learning about and understanding the particular details of your insurance policy. If your policy requires it, you must obtain "Prior Authorization" for your psychiatric treatment. You are also responsible to determine if you have any remaining "Deductible" on your policy (which would need to be paid by you, before your insurance policy would cover the cost of your treatment – exactly the same as an auto insurance policy "deductible").

When patients with a policy "deductible" are seen early in the year (ie January or February), they usually have to pay their deductible for that new year - therefore they receive a higher- than-normal bill. The reason for the higher bill is because your policy's deductible has to be paid. Please call your insurance company to clarify if your policy requires a "prior authorization" or has a "deductible" remaining. If your insurance denies coverage because of such, you are responsible for payment. **Every patient has a different policy with different details, so you must communicate directly with your insurers, to understand the particulars related to your own specific insurance policy.**

6. **SECOND OPINION:**
If at any time you desire a second opinion (with an outside, non-Pelorus provider), please feel free to discuss this with us. We are eager to help you, and will not be offended by such a request.

7. **TMS:**
TMS may be recommended to help improve the symptoms which led you (or your loved one) to seek a consultation. If it is agreed that TMS is indicated, your treating clinician will discuss options that are available to treat your current condition. Information will be presented to you in language that you can understand.
Treatment with TMS or medications of any kind always involves potential risks and benefits. You will learn the expected benefits of TMS, absolute and relative contraindications, possible side effects and risks, its dosage and frequency.
By the end of the discussion you will have all the information you need to make an informed decision as to whether treatment is right for you (or your loved one). If you decide that the benefits of treatment outweigh the risks, treatment will be prescribed and initiated. **If you have questions about TMS, your treating Pelorus medical provider will be happy to answer them.**

8. **CONFIDENTIALITY**:
Confidentiality is the cornerstone of mental health treatment and is protected by the law. We can only release information about you to others with your written permission. Some basic information about diagnosis and treatment may be required as a condition of your insurance coverage.
Exceptions to confidentiality where disclosure is required by law:

- if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization
- if there is threat to harm yourself, we are required to seek hospitalization for the patient, or to contact family members or others who can help provide protection
- if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency
- if you are involved in judicial proceedings, you have the right to seek to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require our testimony
- if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services to provide for your basic needs
- These situations have rarely arisen in our clinical practice, but should such situation occur, we will make every effort to fully discuss it with you before taking any action.

9. TREATMENT CONSENT:

By signing below, you certify that you have read this four-page document and understand the terms stated in this Office Policy and Treatment Consent Form. You understand that you have the right to choose between treatment vs. non-treatment, and that you can always inquire about the risks and benefits of treatment options. You agree that Pelorus TMS will bill you for any missed appointments that were not canceled in advance, per policy number two on the first page. You indicate that you understand the nature of our offered services, the office and payment policies, insurance reimbursement, confidentiality issues, and our contact information, and that you agree to abide by the terms stated above during our professional relationship.

Signed_____ Date_____

Patient
(or Power-of-Attorney)

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Authorization to Release Health Information Pursuant to HIPAA

Patient Name_____ **Birth Date**_____

Authorization: By signing this form, I authorize:

- Any other providers involved in my medical care to release my records to Pelorus TMS.
- Pelorus TMS to release my records to the following people, without requiring a signed release from them:

Psychiatrist or Primary Care Provider: _____

Neurologist / Other Doctors: _____

Therapist: _____

Family / Other (POA, Spouse, Parent, Children, etc): _____

_____

I, or my authorized representative, request and authorize that health care information regarding my care and treatment be released as described below:

Complete medical record (unless otherwise noted here): _____

_____

I *specifically authorize* the release of the following types of highly confidential information: AIDS or HIV, Mental Health Information, Treatment Recommendations, Drug and Alcohol information, and Sexually Transmitted Diseases. (Unless otherwise noted immediately above)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Pelorus TMS.

I understand that signing this authorization is voluntary and that Pelorus TMS, may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal or state privacy regulations.

I have received a copy of this authorization.

Purpose of Release: Records are being released for **continuity of my medical care**, and/or for the reasons specified here: _____

Signature of Patient: _____
(or Authorized Representative, i.e. Power of Attorney)

Date: _____

Name of Authorized Representative (if applicable) _____

Authority of Representative (ie Power of Attorney): _____
(if applicable)

Signature of Witness: _____

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PATIENT DEMOGRAPHIC INFORMATION

Date_____ Referred by:_____

Patient:_____
Last Name First Name Middle Initial

Cell Ph:_____ Home Ph:_____ Email:_____
(indicate preferred method of contact)

Sex: ☐ M ☐ F Age_____ Date of Birth_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Street Address_____ City_____ State_____ Zip_____ Social Security #_____

Psychiatrist or Primary Care Provider:_____ Doctor's Phone:_____

Doc's Fax:_____ Doc's Address:_____

Neurologist:_____ Neurologist's Phone:_____

Neurologist Fax:_____ Neurol's Address:_____

☐ Retired ☐ Working ☐ Student ☐ On Disability Employer/School (if applies)_____

Spouse's Name (or Guardian/Next of Kin)_____

Who is responsible for this account? (i.e. Self, "Power of Attorney", etc.) _____

Relationship to patient: (if other than "Self") _____

Do you have Medical Insurance? ☐ Yes ☐ No If yes:

Name of **Primary** Insurance (i.e. Medicare, Cigna, etc.) _____

Name of **Secondary** Insurance (if any, i.e. AARP, etc.) _____

In case of emergency, who should be notified?_____ Phone #_____

*Credit Card #_____ Type (Visa/MC/Amex)_____ Exp. Date_____

Preferred Pharmacy_____ Phone #_____

Pharmacy Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with:

_____
Name of Insurance Company

And assign directly to Pelorus TMS all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ **Date:**
Signature of Insured/Guardian

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pelorus TMS for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non- covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ **Date:**
Signature of Insured/Guardian

**In the event of late cancellation or no-show for a scheduled appointment, you may be charged a fee to your credit card*

NEW PATIENT INTAKE QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Patient Date of Birth: _____

Who referred you to Pelorus TMS, or how did you find out about this practice?

_____

Reason for seeking TMS treatment (i.e Diagnosis, Symptoms, Recent History)?

_____

_____

_____

_____

Stressors/Precipitants contributing to current situation/symptoms?

_____

_____

Psychiatric Medications

Antidepressant Medications (Including current and past medications)	Dose	Schedule	Start Date	Stopped Date	Reason for Discontinuing Medication
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Patient Last Name

Pelorus TMS

Past Psychiatric History?

Current psychiatrists? _____

Current psychiatric diagnosis? _____

Current psychologist/therapist? _____

Type of Therapy? Individual CBT Group IOP Couple/Family

Start Date? _____ Frequency? _____

Past hospitalizations (location, date)? _____

Any violent, self-injurious, or suicidal behaviors? _____

_____

Past treatment with TMS ("magnetic stimulation") or ECT ("Shock Treatments")?

_____

_____

Substance Abuse History (i.e. Nicotine, alcohol, painkillers, illegal drugs, etc.)?

Do you smoke?_____If so, how many per day? _____

Have you ever smoked?_____For how long?_____How many per day? _____

Do you use or have you used any illegal drugs?_____If so, please describe: _____

_____

Have you misused, abused, or become addicted to any painkillers? _____

Do you consume alcohol?_____If so, please describe the frequency and amount:

_____

Patient Last Name

Past Medical History:

	Yes	No		Yes	No
Vision Loss			Seizures with high fever as a child or baby		
Glaucoma			Head Trauma w/ Loss of Consciousness		
Loss of Hearing			Back pain		
Recurrent Vertigo			Hematological Disorder (Sickle Cell, Hemophilia)		
Hypertension (High Blood Pressure)			Bleeding Tendency		
Dyslipidemia (High Cholesterol)			Diabetes		
History of MI ("Heart Attack")			Thyroid Disease		
COPD/Emphysema			Immunological Disorder (Rheumatoid Arthritis, Lupus, etc.)		
Gastrointestinal Disease			Chronic Allergies/Hay Fever		
Liver Disease			Depression		
Chronic Skin Condition			Psychiatric illness other than depression		
Osteoarthritis/ Degenerative Joint Disease			Kidney Disease, Prostate, or other urological disorder		
Chronic Sleep Disorder			Tuberculosis		
Stroke (CVA)			HIV or AIDS		
Alzheimer's or Other Cognitive Disorder			Encephalitis or Meningitis		
Parkinson's or Other Movement Disorder			Polio		
Essential Tremor			Infections (Lyme, Tuberculosis…)		
Fainting or Blackouts			Gynecological problems		
Seizures/Epilepsy			Any history of cancer		

Please list any other medical illnesses not already described, or clarify any noted above:

_____

_____

_____

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Other Current Medications (please list all medications, dose, and frequency/schedule for each) :

_____
_____
_____
_____
_____
_____

Allergies (medication and food related):

_____

Personal/ Social History

Location born and raised?_____

Education/ Degree?_____

Occupation?_____

For how long?_____ If unemployed or retired, how long?_____

Marital Status?_____ Living situation? (alone, etc.)_____

Children? How many?_____

Any history of being the victim of abuse?_____

Any history of any legal problems, including DUI's?_____

Any family history of neurological or psychiatric illness?_____
_____

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Patient Last Name

REVIEW OF SYSTEMS: PLEASE INDICATE ANY RELEVANT SYMPTOMS BELOW, OR CHECK "N/A" IF NO SYMPTOMS APPLY

	Other:	**N/A**
CONSTITUTIONAL : fever___ fatigue___ night sweats___ weight loss___		
EYES: glasses___ blindness___ double vision___ visual field deficit___ drooping eyelid___		
EAR, NOSE, THROAT: hearing loss___ tinnitus___ infection___ trouble swallowing___ snoring___		
CARDIOVASCULAR: shortness of breath___ chest pain___ edema___ palpitations___ heart murmur___		
PULMONARY: cough___ wheezing___ shortness of breath___ coughing up blood___		
GASTROINTESTINAL: constipation___ vomiting___ diarrhea___ rectal bleeding___ nausea___ abdominal pain___		
SKIN: rash___ itchiness___ ulcers___ lesions___		
MUSCULOSKELETAL: back pain___ joint pain/stiffness___ joint swelling___ muscle cramps or weakness___		
NEUOROLOGICAL: memory loss___ headache ___ tremor___ dizziness___ paralysis or weakness___		
HEMATOLOGICAL/LYMPHATIC: bleeding tendency___ tendency to bruise easily___ history of blood clots___		
ENDOCRINE: increased urination___ increased appetite___ intolerance to heat or cold___ weight loss___ weight gain___		
ALLERGIC/IMMUNO: swollen lymph nodes___ reactions to food or medications___		
PSYCHIATRIC: depression___ anxiety___ panic attacks___ insomnia___ hallucinations___ delusions___		
UROLOGICAL: incontinence___ nocturnal frequency___ burning on urination___ dialysis___ blood in urine___		
INFECTIOUS DISEASE: fever___ night sweats___ known disease___		
OBGYN (women only): pregnant___ painful menses___ abnormal menses___ vaginal discharge___ breast mass___		

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Patient Last Name

TMS ADULT SAFETY SCREEN (TASS) QUESTIONNAIRE

1. Have you ever had an adverse reaction to TMS?
   Yes____ No____
   Comment:_____
   _____
   _____

2. Have you ever had a seizure?
   Yes___ No____
   Comment:_____
   _____
   _____

3. Have you ever had a stroke?
   Yes____ No____
   Comment:_____
   _____
   _____

4. Have you ever had a head injury?
   Yes____ No____
   Comment:_____
   _____
   _____

5. Do you have any metal in your head (outside of your mouth), such as shrapnel, surgical clips, or fragments from welding or metalwork?
   Yes____ No____
   Comment:_____
   _____
   _____

6. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?
   Yes____ No____
   Comment:_____
   _____
   _____

Pelorus TMS

Patient Last Name

7. Do you suffer from frequent or severe headaches?
   Yes____ No____
   Comment:_____
   _____
   _____

8. Have you ever had any other brain-related condition?
   Yes____ No____
   Comment:_____
   _____
   _____

9. Have you ever had any illness that caused brain injury?
   Yes____ No____
   Comment:_____
   _____
   _____

10. Are you taking medication?
    Yes____ No____
    Comment:_____
    _____
    _____

11. If you are a woman of childbearing age, are you sexually active, and if so, are you not using a reliable method of birth control?
    Yes____ No____
    Comment:_____
    _____
    _____

12. Does anyone in your family have epilepsy?
    Yes____ No____
    Comment:_____
    _____
    _____

Patient Signature_____**Date**_____

Pelorus TMS

TMS Patient Screening Form

This section is to be filled out by the PATIENT/or patient representative. *Please indicate if you have any of the following:*

Aneurysms clips or coils		Yes		No	Wearable cardioverter defibrillator		Yes		No
Cardiac pacemaker or wires		Yes		No	Implanted insulin pump		Yes		No
Internal cardioverter defibrillator (ICD)		Yes		No	Programmable shunt or valve		Yes		No
Carotid or cerebral stents		Yes		No	Hearing aid		Yes		No
Deep brain stimulator		Yes		No	Cervical fixation devices		Yes		No
Metallic devices implanted in your head		Yes		No	Surgical clips, staples, or sutures		Yes		No
Dental implants		Yes		No	VeriChip microtransponder		Yes		No
Cochlear implant/ear implant		Yes		No	Wearable monitor (e.g. heart monitor)		Yes		No
CSF (cerebrospinal fluid) shunt		Yes		No	Bone growth stimulator		Yes		No
Eye implants		Yes		No	Wearable infusion pump		Yes		No
Cardiac stents, filters, or metallic valves		Yes		No	Radioactive seeds		Yes		No
Tattoo		Yes		No	Portable glucose monitor		Yes		No
Vagus nerve stimulator (VNS)		Yes		No	Tracheostomy		Yes		No
Blood vessel coil		Yes		No	Medical patch/nicotine patch		Yes		No
Shrapnel, bullets, pellets, BBs, or other metal fragments		Yes		No	Other implanted metal or device If yes, please specify:		Yes		No

Age:_____ Weight (lbs):_____ Height:_____ Last Menstrual period:_____

Have you ever been a machinist, welder, or metal worker?		Yes		No
Have you ever had a facial injury from metal and/or metal removed from your eyes?		Yes		No
Are you pregnant?		Yes		No
Have you ever had a complication from an MRI?		Yes		No

Signature of person completing this form: _____Date: _____

Signature of TMS Coordinator:_____ Date:_____

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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