Welcome to Mid Cities Psychiatry!

In the event of an emergency situation, go to your nearest emergency room or call 911

Thank you for choosing Mid Cities Psychiatry for your psychiatric care! Our team of providers specializes in psychiatry, offering high-quality and specialized behavioral health services with an emphasis on comprehensive psychiatric treatment. Our Medical Director, Dr. Kazi, is exceptional. She oversees our team, provides clinical guidance, is beloved by her patients, and ensures the delivery of exceptional mental health care. Our administrative staff plays a vital role in ensuring the operations run smoothly, handling patient inquiries about billing, appointments, insurance, and more. To help us serve you better, we kindly request that you review and complete the following forms for Psychological treatment in its entirety at least one business day before your appointment.

This document contains important information about this office's professional services for psychological assessment and business policies. Please read it carefully and inform a staff member if you have any questions. When you sign this document, it will represent an agreement between you and our office.

PSYCHOLOGICAL ASSESSMENT SERVICES

The goal of psychological assessment is to answer questions regarding intellectual, academic, social and/or emotional functioning. Obtaining answers to these questions generally involves standardized testing, clinical interviewing, completing questionnaires, observing behavior, and reviewing previous treatment and assessment records (when available).

EVALUATION PROCESS

The psychological assessment process is divided into three sessions.

1. Clinical Interview: This stage consists of a face-to-face interview reviewing various aspects of your history, presenting concerns, reason for the evaluation, and determination of applicable testing.
2. Testing session(s): A battery of psychological tests will be selected to answer the referral question. Length of the session depends on the referral question. For example, a comprehensive evaluation to assess cognitive functioning, possible attention deficits, mood, and/or personality functioning, a four-hour testing session is typically required. After the testing is completed, the psychologist scores and interprets all tests and writes the report.
3. Feedback Session: For psychological assessments, the feedback session is scheduled two to three weeks after the testing session. At that time, you will be provided with an unofficial copy of your report and the psychologist will explain the testing results, diagnostic impressions, and treatment recommendations and resources. If revisions are needed to the unofficial report, this will be completed by the psychologist. The official report is then available to be mailed or picked up by the patient. The official report is faxed directly to anyone indicated on your test release. However, no completed report will be given to a patient unless he or she participates in the final feedback session with the examiner. Finally, the psychologist does not provide raw data to test patients.

COMPLETION TIME

Due to the complex nature of psychological testing, your evaluation may take up to 8 weeks after your initial Clinical Interview before completion. If you would like your evaluation earlier, it is possible to expedite turn-around time for a fee by discussing with your psychologist the emergent need and possible options.

RISKS AND BENEFITS

The primary benefits of psychological assessment include diagnostic clarification, appropriate treatment recommendations to handle challenges and maximize strengths, a written report to facilitate services and communication with treatment providers, and insight into the nature of your functioning. Although many individuals have an overall positive experience during the assessment process, there are some risks. The person undergoing assessment may experience discomfort, frustration, anxiety, or embarrassment during the process. It is possible that the assessment will not answer all of your questions, and further evaluation may be needed. While the assessment and treatment recommendations are based on best practices, you or others may not agree with the conclusions. It is your decision whether to follow the recommendations. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations. You also have the right to discontinue the evaluation process at any time. However, you agree and understand that Mid Cities Psychiatry may be unable to provide feedback of the test results of testing is terminated, and that you will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.

CANCELLATION POLICY, NO SHOWS, AND LATE ARRIVALS

Once a testing appointment is scheduled, you will be expected to pay a late cancellation fee or missed appointment fee unless you provide 48 hours advance notice of cancellation.

- A 50% waiver/refund is available without requiring a doctor's note: for the first hour. $150 per hour for the rest of the hours will be charged
- A 100% waiver/refund is provided upon submission of a doctor's note: for the first hour. $150 per hour for the rest of the hours will be charged

It is important to note that insurance companies do not provide reimbursement for canceled sessions. If it is possible, Mid Cities Psychiatry will try to find another time to reschedule the appointment. If you arrive late for a scheduled testing appointment, only the remainder of the testing session will be available. A second testing session may be required to complete the tests selected. It is Mid Cities Psychiatry policy that if you arrive 15 minutes late to your scheduled testing appointment, without notice, it will be considered a no-show, and you will be responsible for the missed appointment fee. In the case of inclement weather and an office closure, Mid Cities Psychiatry will make every effort to contact you via telephone or e-mail to reschedule the appointment.

FEES

When billing insurance companies, the patient is usually billed for an initial clinical interview, testing hours, and the final feedback session when the test results are reviewed. If there is a deductible, co-pay or co-insurance, you must pay the entire fee at the time of the initial visit. It is against regulations from the insurance company for us to see a patient without collecting their patient responsibility. Mid Cities Psychiatry reserves the right to turn over any uncollected debt (over 30 days) to a collection agency and/or magistrate's court. Insurance does not cover these types of services.

COURT TESTIMONY

Should you become engaged in legal proceedings necessitating the involvement of your psychologist, you are required to compensate for all associated professional services rendered by the psychologist. This includes preparation, travel expenses, and any court appearances, irrespective of which party summons the psychologist to testify. Moreover, should you compel the psychologist to testify on your behalf through a subpoena or court order—whether in deposition, in court, or via telephone—Mid Cities Psychiatry is unable to bill these services to health insurance. Consequently, you are obligated to provide a nonrefundable retainer of $1,500 at least five business days prior to the court date. This retainer will cover a full day of your psychologist's professional time. By signing this agreement, you acknowledge and accept Mid Cities Psychiatry's policy of non-participation in legal proceedings unless legally mandated by subpoena or court order.

CONFIDENTIALITY/LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, Mid Cities Psychiatry can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. For assessment patients, information will only be released verbally or in writing to people that you give us permission to speak with. You will provide us with that permission by completing a *Release of Information* form. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. The psychologist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, the psychologist will make every effort to avoid revealing the identity of their patient. The other professionals are also legally bound to keep the information confidential. If you do not object, the psychologist will not tell you about these consultations unless they feel that it is important to our work together. The psychologist will note all consultations in your Clinical Record.
2. If a patient threatens to harm himself/herself, the psychologist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where the psychologist is permitted or required to disclose information without the patient's consent or Authorization:

1. If a patient is involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. The psychologist cannot provide any information without patient's (or patient's legal representative's) written authorization or court order.
2. If a subpoena is served on the psychologist with appropriate notices, the psychologist may have to release information in a sealed envelope to the clerk of the court issuing the subpoena
3. If patient is involved in or contemplating litigation, patient should consult with his/her attorney to determine whether a court would be likely to order the psychologist to disclose information.
4. If a government agency is requesting information for health oversight activities, the psychologist may be required to provide it for them.
5. If a patient files a complaint or lawsuit against the psychologist, the psychologist may disclose relevant information regarding that patient in order to defend themselves.
6. If a patient files a worker's compensation claim, the psychologist must, upon appropriate request, provide a copy of any mental health report.

There are some situations in which the psychologist is legally obligated to take actions, which are necessary to attempt to protect others from harm and the psychologist may have to reveal some information about a patient's treatment:

1. If the psychologist has reason to suspect that a child is abused or neglected, the law requires them to file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, the psychologist may be required to provide additional information. If the psychologist has reason to suspect that an incapacitated adult or an adult over age 60 is abused, neglected, or exploited, the law requires that the psychologist report to the Department of Welfare or Social Services. Once such a report is filed, the psychologist may be required to provide additional information.
2. If a patient communicates a specific threat of immediate serious physical harm to an identifiable victim, and the psychologist believes he/she has the intent and ability to carry out the threat, the psychologist is required to take protective actions. These actions may include notifying the potential victim or his/her guardian, contacting the police, or seeking hospitalization for the patient.
3. In the event of an emergency that takes place in our office. If any of these events happen, Mid Cities Psychiatry will let you know that we are reporting this information to the proper authorities.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
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Seema Kazi, MD, PA

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail / texts and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Practice Duties

Law requires us law to maintain privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact us to let us know. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

_____

(please initial)

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

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CONTACTING THE PSYCHOLOGIST

Due to the psychologist's work schedule, they are often not immediately available by telephone. The psychologist will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform the psychologist of some times when you will be available. If you are unable to reach the psychologist and feel that you cannot wait for them to return your call, contact your family physician or the nearest emergency room.

OUR PROFESSIONAL RELATIONSHIP

As a professional, the psychologist will use their knowledge and skills to help you as best they can. This includes the standards of the American Psychological Association (APA) and the Texas State Board of Examiners of Psychologists (TSBEP). In your best interests, these entities put limits on the relationship between psychologist and patient, and the psychologist will abide by these boundaries. First, the psychologist is licensed to practice clinical psychology, not law, medicine, financial planning, or any other profession. Thus, the psychologist is not able to give you appropriate and qualified advice from these other professional viewpoints. Second, state law and the rules of the APA require the psychologist to keep what you tell them confidential (private). You can trust the psychologist not to tell anyone what you tell them, except in limited situations (described in the Confidentiality section). The psychologist will make every effort to avoid outing you as one of their patients. Thus, if we meet in the mall, on the street, or in another social setting, the psychologist will not approach you or initiate contact unless you initiate contact first. Moreover, even if you initiate contact, the psychologist may limit any contact initiated by you. Their behavior is not intended to be a personal reaction to you; rather, their behavior is intended to protect your confidentiality.

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

_____ (initial) I have read and understand the information contained in the document entitled Practice Policies and Informed Consent for Psychological Services and agree to abide by its contents and consent to receive psychological services from Mid Cities Psychiatry.

_____ (initial) Fees for services have been discussed with me and I understand that I am ultimately responsible for payment of services.

_____ (initial) I understand policies regarding confidentiality and the limits of confidentiality.

_____ (initial) I have been provided with the document entitled Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information. By signing below, you are providing written informed consent to proceed with receiving psychological services in the form of psychological assessment from Mid Cities Psychiatry.

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Registration Form

DemoGraphics

Name		Male ☐	Female ☐	Date			
SS #		DOB		e-mail			
Address		City		State		Zip	
Home #		Work #		Cell #			
Person Completing Form				Relationship To Patient			
Referring MD		Primary Care Physician					
Handedness	Right-Handed ☐	Left-Handed ☐ | Both ☐ |					
Race	American Indian or Alaska Native ☐	Asian ☐	Black or African American ☐	Native Hawaiian or Other Pacific Islander ☐		White ☐	Other ☐

Self-Pay Or Insurance

Are you a self-pay? Yes ☐ | No ☐ <> If YES, please go to the next page, If NO, please continue

Primary Insurance Name _____ must attach primary insurance card

Secondary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach secondary insurance card

Tertiary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach tertiary insurance card

Medicare Patient
As per the policy of this clinic, Medicare patient is <u>required</u> to complete/sign "Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R131" last page of this Registration-Form.

_____ (please initial)

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EARLY HISTORY AND DEVELOPMENT

Were you born	On time ☐	Prematurely ☐	Late ☐	Birth weight	

Were there any problems associated with your mother's pregnancy (describe)

Your birth (e.g., oxygen deprivation, unusual birth position, etc.)

The period immediately after birth (e.g., need for oxygen, special equipment used, convulsions, illness, NICU, etc.)

Rate your developmental progress to the best of your knowledge, in months: Early ☐ Average ☐ Late ☐

Walking (10-16 mos). Language (12-24 mos) Toilet training (18-36 mos)

As a child, did you have any of these conditions? (Check all that apply)

Frequent Ear Infections. ☐	Head Injury. ☐	Behavioral Problems. ☐	Social problems. ☐
Hearing Problems. ☐	Speech Problems. ☐	Developmental Delays. ☐	Hyperactivity. ☐
Vision Problems. ☐	Attention Problems. ☐	Learning Disability. ☐	Psychological Problems. ☐

If yes to any of the above, please explain

Other problems during childhood

MEDICAL HISTORY

Medical illnesses as a child

Medical illnesses as an adult

Surgeries as a child or adult

Do you have hearing problems? Yes ☐ No ☐	Do you have vision problems? Yes ☐ No ☐
Have you ever suffered an injury to your head? Yes ☐ No ☐	If Yes, did you lose consciousness? Yes ☐ No ☐

When? Please explain the circumstances, medical interventions and any problems afterwards

Alcohol Screening Questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times a Month	2-3 Times a Week	4 or more Times a Week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M	0-4	5-14	15-19	20+
W	0-3	4-12	13-19	20+

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NICOTINE/MARIJUANA/DRUG INTAKE

Previous Substance Abuse		
Name of Substance	Age started using	Age stopped using

Current Substance Abuse		
Name of Substance	Age started using	How much do you use?
Smoke (yes/no)	Drink (yes/no, if yes, do survey)	Vape (yes/no)

SLEEP/APPETITE/SEXUAL INTEREST/EXERCISE

Describe your recent sleep: Insomnia ☐ Early Phase ☐ Middle Phase ☐ Late Phase ☐ Hypersomnia Yes ☐ No ☐

Describe your recent appetite

Recent weight loss? Yes ☐ No ☐ Recent weight gain? Yes ☐ No ☐

Have you noticed any recent changes in your sexual interest? Yes ☐ No ☐

Describe your current exercise routine?

PREVIOUS/CURRENT MEDICATIONS (Psychiatric/Sleep Medications/Supplements) (please *attach list if any*)

Medications	**Dose**	**Start/End Date**	**Side Effects**	**Directions**
Anti-Depressant	**Dose**	**Start/End Date**	**Side Effects**	**Directions**

Medications Allergies	
Name	**Reaction**

FAMILY HISTORY

Where were you born? Where were you raised?

Do you live alone or with others? (if with others, whom?)

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Spouse's Name

Gender Identity **Sexual Orientation**

Family Psychiatric History

Relationship	Living/Passed	Age	Psychiatric History
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Son/Daughter			
Son/Daughter			
Son/Daughter			

Family Psychiatric History (cont)

Have any of your family members experienced the following health issues? Please specify which relatives on your mother's side (maternal) and father's side (paternal) were affected.

Health Issues	**Relationship**	Maternal / Paternal
Depression		
Suicidal Ideation/Attempt		
Homicidal Ideation/Attempt		
Anxiety		
Panic Attacks		
PTSD		
Bipolar Disorder		
OCD		
Schizophrenia		
ADHD		
Learning Problems		
Autism Spectrum		
Alcohol Abuse		
Drug Abuse		

PSYCHIATRIC HISTORY

Please list any psychiatric or learning disorders including ADHD, Alzheimer's, dyslexia, depression, anxiety, eating disorders, manic depression, substance abuse)

Diagnosis	Year Diagnosed	Diagnosing Provider

Previous Psychiatric Hospitalizations/Rehab (Residential Treatment Center (RTC))		
Diagnosis	Year	Treating Provider

Medical History (*seizure disorders, diabetes, heart problems etc.)*		
Diagnosis	Year	Treating Provider

Past Surgical History		
Procedure	Date of Procedure	Treating Provider

Do you experience any of the following:

Memory Problems ☐	Hyperactivity ☐	Occupational Problems ☐	Anxiety ☐
Lack of Energy ☐	Outbursts of Rage ☐	Appetite Fluctuations ☐	Impulsivity ☐
Parenting Problems ☐	Attention Problems ☐	Mood Swings ☐	Depression ☐
Communication Problems ☐	Loneliness ☐	Poor Hygiene ☐	Mania ☐
Conflict with Children ☐	Posttraumatic Stress ☐	Poor Body Image ☐	Lying ☐
Self-control Problems ☐	Domestic Violence ☐	Low Self Esteem ☐	Stress ☐
Religious/Spiritual Problems ☐	Divorce/Separation ☐	Racing Thoughts ☐	Anger ☐
Difficulty Making Decisions ☐	Marital Problems ☐	Sexual Dysfunction ☐	Fatigue ☐
Lack of Motivation ☐	Social Problems ☐	OCD Tendencies ☐	Stealing ☐
Family of Origin Conflicts ☐	Nightmares ☐	Financial Problems ☐	

Have you ever been abused? Yes ☐ No ☐ If yes: Sexual ☐ Verbal ☐ Emotional ☐ Physical ☐

If yes, who was the abuser and please describe:

Have you ever experienced any other traumatic event(s)? Yes ☐ No ☐

If yes, please describe

Patient Health Questionnaire (PHQ-9)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of 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…….				
	Your PHQ-9 Scale Total Score Is….				

If you checked off any of the 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	

Mid Cities Psychiatry provides Transcranial Magnetic Stimulation aka TMS Therapy.
TMS Therapy is an alternative treatment for patients suffering from depression for whom medication has proven ineffective. and provides new hope for people who want to reduce or possibly eliminate the use of prescription medications to treat their depression.
Patient agrees to be contacted by a patient advocate to know more about TMS Therapy….

_____ Yes _____ No

_____ Name of Patient _____ Date of Birth

_____ Signature of Patient or Responsible Party (if minor Patient) _____ Date

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Legal History (if any current or previous convictions, please give detail)			
Arrest Date	**Charge**	**Convicted (yes/no)**	**Sentence**

Are you currently on Probation? Yes ☐ No ☐ Parole? Yes ☐ No ☐ End Date?

Are you involved in any lawsuits? Yes ☐ No ☐ Any upcoming Court dates?

If yes, on lawsuits, please describe:

Military Service	
Type	**When**
Type of Discharge (explain if dishonorable)	
Describe any combat experience	
Are you troubled now by your military experience?	

Employment/Education	
Name	**Description**
Employed (yes/no)	
Occupation/Name Company	
Full Time/Part Time	
Disabled	
Retired	
Unemployed	
High School Diploma	
College Degree	
Academic Performance	
Preferred Areas of Study	
Attitude toward Academic Achievement	
Possibilities for Future Education	

Do you have any difficulties at your job (tardiness, excessive absenteeism, difficulty interacting with clients, fellow workers, and supervisors, excessive errors, unapproachable, etc.)

Do you hold a valid driver's license? Yes ☐ No ☐ Do you currently drive? Yes ☐ No ☐

Activities Of Daily Living

Describe any problems completing normal activities of living (cooking, cleaning, driving, etc.):

Do you hold a valid driver's license? Yes ☐ No ☐ Do you currently drive? Yes ☐ No ☐

Hobbies

Please provide any additional information you think we should know

Adolescent Educational History

The following section is specifically for adolescents. If you are not an adolescent, please skip this section and proceed to sign the form below. If the patient is an adolescent, a parent or guardian must complete the following section:

High School Name Graduated

Behavior problems at school?

Describe your child's usual performance as a student: A & B ☐ B & C ☐ C & D ☐ D & F ☐

Please provide any additional helpful comments about your child's academic performance:

Has your child repeated a grade? Yes ☐ No ☐

If yes, which grade?

Was your child ever in any special education class(es) or did he/she receive special services for learning difficulties? Yes ☐ No ☐

If yes, please describe

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