THE TMS COLLABORATIVE

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The TMS Collaborative Authorizations

9 Hampton Rd. Exeter, NH 03833 - Phone: 603-778-0505
www.tmscollaborative.com

Insurance Authorization - For rTMS Therapy Insurance networks commonly require prior authorization before you begin treatment. In an effort to help protect each of our patients, we attempt to ensure appropriate authorization is obtained from your health insurance company prior to treatment.

Most insurances will require the following:
•A diagnosis of depression (moderate to severe)
•A minimum of 2 to 4 antidepressant trials with little or no benefit from symptoms or medication discontinuation due to side effects.
•A history of psychotherapy (therapists, counselor, group therapy, outpatient therapy, extended visits with a psychiatrist, or psychologists)
•No history of seizures
•No rTMS Therapy treatment contraindications
•Insurance companies require medical record documentation of all of the above, including other qualifying information, in order to obtain prior authorization for rTMS therapy services. The TMS Collaborative will request your medical records from your behavioral health care providers in order to have this information on file and for insurance pre-authorization.

The TMS Collaborative will submit a prior authorization to your insurance upon receipt of all required documentation from you and your current or previous behavioral health care providers. Therefore, by signing this form you grant permission for The TMS Collaborative to submit a prior authorization request to your insurance provider for any treatment services and/or for services to be provided to you by one of our physicians or healthcare providers? By signing below, I acknowledge that The TMS Collaborative will submit a prior authorization to my insurance upon receipt of all required documentation from me and or my current or previous behavioral health care providers. I provide permission for The TMS Collaborative to submit a prior authorization request to my insurance provider for TMS therapy (transcranial magnetic stimulation) and/or for services to be provided to you by one of our physicians or healthcare providers.

Insurance and Financial Responsibility Information: 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 preauthorization 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 benefits checks and pre-authorization are not a guarantee of payment. Pre-authorization is intended for your benefit and to help ensure payment from your insurance provider. If pre-authorization is obtained, but your insurance provider rejects services, you may still be responsible for the 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 the course of treatment and it is your responsibility to notify our office of any changes. In some instances, clients may receive a statement due to insurance changes or other reasons. We accept payment via credit card, cash, or health savings card (HSA) at each location. We do not accept credit card payments over the phone and do not keep credit or debit card information on file within our billing system.

Cancellation Policy: For cancellations made 24 hours or more in advance, no charge will be incurred by the patient for a cancelled appointment. If a patient does not call within 24 hours to cancel their appointment, they will be charged $50. We understand that emergencies and unexpected events occur. In those cases, please call the office as soon as you are able to explain to the staff what occurred and they will determine whether you are subject to a cancellation fee or not. By signing below, I understand and acknowledge The TMS Collaborative PPLC's cancellation policy and the fees associated with it.

Patient Acknowledgment: by signing this form, you're acknowledging to the best of The TMS Collaborative PLLC's ability they have answered your treatment-related questions. I am also aware of the HIPAA Notice and Patient Privacy Act. I am informed of The TMS Collaborative Hearing Protection Policy and I understand I may elect to decline to wear earplugs during treatment.

Any treatment-related questions I had prior to treatment were asked and answered to my satisfaction. If I am not aware of any, or all of the above notices or policies, I will request a further explanation from The TMS Collaborative prior to acknowledging this document. I also agree to not hold The TMS Collaborative and each of its employees and physicians liable from any adverse side effects or events that may result from any and all of my interventional psychiatry treatments with The TMS Collaborative. I fully understand the indications for and any side effects of rTMS Therapy including an explanation of clinic treatments I am seeking for major depression or any other diagnoses. For the therapy I am seeking, I have had all of my questions and/or concerns answered. Therefore, I authorize The TMS Collaborative to communicate with my health insurance company and any clinicians that I have received or am seeking treatment at The TMS Collaborative. Therefore, for the purpose of any pre-authorization and for any other purposes that may arise as a result of my relationship with The TMS Collaborative, my signature below acknowledges that I have read or I have waived the right to read The TMS Collaborative's guide for any of their therapies.

Name *

First Name Last Name

Birthday *

Month Day Year

Email

example@example.com

Address *

Street Address

Street Address Line 2

Cell Phone Number

Please enter a valid phone number.

Emergency Contact Name *

First Name Last Name

Emergency Contact Phone Number *

Please enter a valid phone number.

Today's Date *

Month Day Year

CONSENT TO RELEASE MEDICAL INFORMATION

TMS COLLABORATIVE

9 HAMPTON RD, UNIT 2, EXETER, NH 03833

603-778-0505

Name

First Name Last Name

Birthday

Month Day Year

I hereby authorize the below providers to use or disclose, in verbal and/or written form, the specific information requested below, to The TMS Collaborative PLLC for the purpose of receiving TMS therapy treatment for the purpose of obtaining insurance prior- authorization this treatment.

Clinician that prescribes you your behavioral health medications

Prefix First Name Last Name Suffix

Phone Number

Area Code Phone Number

Fax Number

Area Code Phone Number

Primary Care Clinician if different from above

Prefix First Name Last Name Suffix

Phone Number

Area Code Phone Number

Fax Number

Area Code Phone Number

Current of past Therapist

Prefix First Name Last Name Suffix

Phone Number

Area Code Phone Number

Fax Number

Area Code Phone Number

Type of Medical Information to be disclosed

All Medical Records

Current / Previous Medications

Other Information allowed to be disclosed

I give consent to the release of information pertaining to drugs and alcohol

I give consent to the release of information pertaining to mental health diagnosis or treatment.

Information is being requested for the following purpose(s): Repetitive Transcranial Magnetic Stimulation (rTMS therapy) and this authorization shall remain in effect for 1-year from the below date of consent. I understand that I may inspect or copy the protected health information to be used or disclosed. I understand that I may revoke this authorization any time before the expiration date (except to the extent that actions have been taken in reliance on it) by submitting a written revocation letter to The TMS Collaborative. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. I may refuse to sign this authorization and I hereby release The TMS Collaborative PLLC from any and all legal responsibility or liability or for any

consequences of either: 1) having non-stipulated information maintained in confidence or privacy, or 2) disclosing stipulated

Date Signed

Month Day Year

NOTICE TO RECEIVING AGENCY: The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.

Parent or Legally Authorized Representative

In case the subject is beyond the legal age of consent:

Name of Parent or Guardian

First Name Last Name

Relationship to Subject

Date Signed

Month Day Year

Diagnosis and Antidepressant History

Please select all that apply and use drop down boxes where appropriate

Name

First Name Last Name

What is the patient's primary diagnosis?

F33.1 Major depressive disorder, recurrent, moderate

F33.2 Major depressive disorder, recurrent severe without psychotic features

Other Diagnosis

If diagnosis is other please describe below

Lifetime Antidepressant History - Please select all that apply

	Select All That Apply	Dosage - Select From Dropdown	Duration - Approx. Year Started and Length of Time Used	Current or Reason For Discontinuation - Dropdown
Citalopram (Celexa)				
Escitalopram (Lexapro)				
Fluoxetine (Prozac)				
Fluvoxamine (Luvox)				
Paroxetine (Paxil)				
Sertraline (Zoloft)				
Desvenlafaxine (Pristiq)				

Duloxetine
(Cymbalta)

Levomilnacipran
(Fetzima)

Venlafaxine
(Effexor)

Vilazodone
(Viibryd)

Vortioxetine
(Trintellix)

Trazodone
(Desyrel)

Bupropion
(Wellbutrin)

Amitriptyline
(Elavil)

Clomipramine
(Anafranil)

Desipramine
(Norpramin)

Doxepin
(Adapin)

Imipramine
(Tofranil)

Nortriptyline
(Pamelor)

Maprotiline
(Ludiomil)

Mirtazapine
(Remeron)

Any Antidepressant Rx that isn't on the above list can be listed in the space below

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

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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