1220 Main Street, Suite 431, Vancouver, WA 98660
(503) 974-4831 Fax (888) 569-3218

Prospective Patient Information and Forms Packet

TMS, or Transcranial Magnetic Stimulation, is FDA approved for the treatment of adults aged 22-70 suffering from moderate to severe major depressive disorder that has not adequately responded to medications and therapy. If you believe you meet these criteria and would benefit from TMS therapy, please fill out the enclosed forms and return them to us. You may send them to us via fax or USPS mail, or email them to info@serenitytms.com.

- ☐ **Insurance Information Form**: This form will allow us to investigate your insurance benefits to determine coverage for TMS therapy.
- ☐ **New Patient Registration:** Your demographics and contact information
- ☐ **Patient Clinical History Questionnaire:** This form will ask you for basic clinical information that is required by most insurance companies for coverage of TMS.
- ☐ **Authorization to Release Information:** This form gives your medical or psychiatric prescriber permission to provide us with clinical documentation necessary for determining appropriateness of the treatment and obtaining insurance authorization for coverage of TMS.
- ☐ **PHQ-9** and **GAD-7**: These are brief questionnaires that provide a measure of the severity of your current symptoms.

When we receive your completed forms, someone from our office will contact you within 1-2 business days with information about your insurance plan's coverage for TMS, and to schedule a consultation by phone or in person so we can gather any additional information we need, as well as answer your questions about TMS and our clinic.

We look forward to working with you!

Sincerely,

The providers and staff of Serenity TMS, PLLC

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Today's Date: _____

INSURANCE INFORMATION	
Patient Name	**DOB**
Address	**Phone**
City / State / Zip	**Email**

PRIMARY INSURANCE COMPANY	
Name	**Phone**
Address	**ID Number**
City / State / Zip	**Group Number**
Policy Holder Name (if other than self)	**DOB**
Address (if different than above)	**Phone**
City / State / Zip	**Relationship to insured**

SECONDARY INSURANCE COMPANY	
Name	**Phone**
Address	**ID Number**
City / State / Zip	**Group Number**
Policy Holder Name (if other than self)	**DOB**
Address (if different than above)	**Phone**
City / State / Zip	**Relationship to insured**

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NEW PATIENT REGISTRATION

Full Name:_____ Preferred Name: _____

DOB:_____ Gender: ◯ M ◯ F ◯ Trans ◯ Other:_____

Address:_____

City, State, Zip:_____

Phone #1:_____ ◯ Mobile ◯ Home ◯ Work

Phone #2:_____ ◯ Mobile ◯ Home ◯ Work

E-mail:_____

Primary Care Provider:_____ Phone:_____

Psychiatric Prescriber:_____ Phone:_____

Therapist:_____ Phone:_____

Pharmacy:_____ Phone:_____

How did you hear about us? _____

Emergency Contact:_____ Phone:_____

Relationship to you: _____

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TMS Patient Clinical History Questionnaire

Patient Information:

Name: _____ Age: _____ DOB: _____

Antidepressant Medication History:

	Medication	Date (s)	Dosage	Duration	Outcome, side effects
1					
2					
3					
4					
5					

ECT (Electroconvulsive Therapy):

If you have had ECT, please list approximate dates of treatment and the outcome:

_____

Psychotherapy:

Start date: _____ End date: _____ Visits per week: _____ Outcome: _____

Start date: _____ End date: _____ Visits per week: _____ Outcome: _____

Inpatient Psychiatric Hospitalizations:

When: _____ Where: _____ How Long: _____

When: _____ Where: _____ How Long: _____

Please answer the following questions:

- Do you have any non-removable metal objects in your head or neck? ◯YES ◯NO
  Examples: Cochlear implants, deep brain stimulators, implanted electrodes, vagus nerve stimulators, aneurysm clips or coils, stents, CSF shunts, staples, metallic sutures, bullet fragments
- Do you have any implanted medical devices? ◯YES ◯NO
  Examples: Pacemakers, defibrillators
- Do you have any facial tattoos or permanent makeup? ◯YES ◯NO
- Do you have any history of seizures? ◯YES ◯NO
- Do you have any history of stroke or head injury? ◯YES ◯NO

Please list all medications you are currently taking:

Medication Name	Dose	Frequency

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AUTHORIZATION TO RELEASE INFORMATION

Patient Information:

Name: _____

Address: _____

City, State, ZIP: _____

Date of Birth: _____ Phone Number: _____

Provider Information:

Provider / Clinic Name: _____

Address: _____

City, State, ZIP: _____ Phone Number: _____

I hereby authorize the provider named above to release the following information to Serenity TMS, LLC for the purpose of determining whether Transcranial Magnetic Stimulation (TMS) therapy is an appropriate and medically necessary treatment for me:

- ✓ Psychiatric diagnoses
- ✓ Intake note and most recent visit notes OR Clinical summary
- ✓ Psychiatric medication history including dosage, dates of therapy, and outcomes
- ✓ Current medication list
- ✓ Recent diagnostic measurement scores (e.g. PHQ-9)
- ✓ Psychotherapy history (dates, duration, frequency, outcomes)
- ✓ ECT treatment dates and outcomes, if applicable

I understand this information may be redisclosed by Serenity TMS, PLLC, for the purpose of requesting authorization from my insurance plan for TMS therapy. This authorization may be revoked at any time by my written statement except to the extent that action has already been taken on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions *(Specify)*:

_____

_____ _____

Patient Signature Date Staff Signature Date

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**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)