TMS Therapy Registration Form

Novus
Neurology | Psychiatry | TMS

Novus Neurology I Psychiatry ITMS
2201 Jack Warner Parkway
Tuscaloosa, AL 35401
Phone: (205) 523-5618
Fax: (205) 860-6332

Dear Client:

Thank you for choosing Novus TMS to be your TMS therapy provider. When you choose our service, you become a part of a compassionate, supportive team of professionals that will be with you throughout your TMS journey to a better quality of life.

As part of our registration process, most insurance companies require a prior authorization before starting treatments. We ask that you complete these forms as thoroughly as possible to ensure appropriate authorization from your insurance before scheduling your first TMS treatment session.

We will need objective scores of your depression using the BDI-2 and PHQ-9 score sheets below. Please read each question carefully and select the best answer. If you are uncertain between two choices, choose the higher answer.

In addition, we will need an accurate list of the medications you have taken for your depression or other mood disorder(s) and if they were helpful, unhelpful, and/or if you experienced any side effects with them. Please provide the name of the medication (brand or generic name), dose, the start date and stop dates. If you are unable to remember specific dates, please fill-in an approximate date to the best of your knowledge. You should check with your pharmacy(s) or pharmacy app to obtain the most accurate information available.

Most insurances will require the following information:

- ☐ Diagnosis of Depression
- ☐ BDI-2 score ≥ 30
- ☐ PHQ-9 score ≥ 20
- ☐ 2-4 antidepressant trials
- ☐ History of psychotherapy (CBT, interpersonal therapy, DBT, EDMR, etc.)

Upon completion of your initial TMS therapy evaluation with your designated provider and completion of these forms, you may be considered for TMS therapy. The reviewing health care provider will discuss this with you and answer questions you may have.

We thank you for taking the time to complete the TMS Registration Form and look forward to providing excellent care throughout this process.

Sincerely,

Novus Neurology I Psychiatry I TMS Providers and Staff

TMS Therapy Registration Form

Date: _____

PATIENT INFORMATION:

Patient's Full Name: _____ Date of Birth: ____/____/____

Full SSN: _____ - _____ - _____ Gender: _____

Marital Status: ____ Single ____Married ____Divorced ____Widowed Other _____

CONTACT INFORMATION:

Address: _____ Apt/Lot/Unit: _____

City: _____ State:_____ Zip Code: _____

Cell: _____ Home: _____ Work: _____

Email Address for Patient Portal Access: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Client: _____

Phone Number: _____

May we contact and leave a message with this person: (please circle) Yes No

PROVIDER INFORMATION:

Primary Care Doctor Name: _____ Location:_____

Phone Number:_____ When was your last appointment? _____/_____/_____

Psychiatrist Name: _____ Location: _____

Phone Number:_____ When was your last appointment? _____/_____/_____

Therapist Name: _____ Location: _____

Phone Number:_____ When was your last appointment? _____/_____/_____

How did you hear about TMS therapy? _____

PHARMACY INFORMATION:

Preferred Pharmacy Name: _____

Pharmacy Address: _____

City/State: _____ Zip Code: _____

Do we have permission to contact your pharmacy? ( ) Yes ( ) No

INSURANCE INFORMATION:

Primary Insurance Name: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Secondary Insurance Name: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Tertiary Insurance Name: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other _____

If it is required by your insurance provider, do you give Novus TMS permission to submit a prior authorization request to your insurance provider? ( ) Yes ( ) No

ADDITIONAL INFORMATION

What age were you diagnosed with depression? Age: _____

Have you ever been in remission from depression? ( ) Yes ( ) No If yes, for how long? _____

When did your current episode of depression begin? Date: _____

Additional Comments: _____

_____

In your own words, how has depression affected the quality of your life and everyday functioning?

_____

_____

_____

_____

_____

We will assess your current symptoms of depression on the upcoming forms using the BDI-2 and PHQ-9 depression screening forms.

THERAPY INFORMATION

Are you currently participating in psychotherapy?

Therapist Name: _____ Dates: _____

Location: _____ How often do you attend therapy sessions? _____

What type of therapy? ( ) CBT ( ) EMDR ( ) DBT ( ) Interpersonal Psychotherapy

( ) Group ( ) Humanistic ( ) Psychoanalytic or Psychodynamic therapy

( ) Other: _____

Have you participated in psychotherapy in the past? ( ) Yes ( ) No

Prior Therapist Name: _____ Dates: _____

Location: _____ How many sessions did you attend? _____

What type of therapy? ( ) CBT ( ) EMDR ( ) DBT ( ) Interpersonal Psychotherapy

( ) Group ( ) Humanistic ( ) Psychoanalytic or Psychodynamic therapy

( ) Other: _____

Prior Therapist Name: _____ Dates: _____

Location: _____ How many sessions did you attend? _____

What type of therapy? ( ) CBT ( ) EMDR ( ) DBT ( ) Interpersonal Psychotherapy

( ) Group ( ) Humanistic ( ) Psychoanalytic or Psychodynamic therapy

( ) Other: _____

Has therapy helped to resolve your symptoms of depression? ( ) Yes ( ) No

Have you ever been in an Intensive Outpatient Program for depression? ( ) Yes ( ) No

Location: _____ How many sessions did you attend? _____

Approximate Dates: _____

Have you been hospitalized for depression in the past? ( ) Yes ( ) No

Hospital Name: _____ Approximate Dates: _____

Have you ever had Transcranial Magnetic Stimulation (TMS therapy)? ( ) Yes ( ) No

Provider Name: _____ Clinic Name:_____

Dates (Start Date and Stop Date): _____

Did you have greater than a 50% improvement in your symptoms? ( ) Yes ( ) No

Have you ever had Electroconvulsive Therapy (ECT)? ( ) Yes ( ) No

Provider Name: _____ Clinic Name:_____

Dates (Start Date and Stop Date): _____

BDI-2 DEPRESSION SCALE

NAME: _____ DATE: ____/ ____ / _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully. And then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Click the number below the statement you have picked. If several statements in the group seem to apply equally well, choose the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. **Sadness:**
0. I do not feel sad. 1. I feel sad much of the time. 2. I am sad all the time. 3. I am so sad or unhappy that I can't stand it.

□ 0 □ 1 □ 2 □ 3

2. **Pessimism:**

0. I am not discouraged about my future. 1. I feel more discouraged about my future than I used to.

2. I do not expect things to work out for me. 3. I feel my future is hopeless and will only get worse.

□ 0 □ 1 □ 2 □ 3

3. **Past Failure:**

0. I do not feel like a failure. 1. I have failed more than I should have. 2. As I look back, I see a lot of failures. 3. I feel I am a total failure as a person.

□ 0 □ 1 □ 2 □ 3

4. **Loss of Pleasure:**

0. I get as much pleasure as I ever did from the things I enjoy. 1. I don't enjoy things as much as I used to. 2. I get very little pleasure from the things I used to enjoy. 3. I can't get any pleasure from the things I used to enjoy.

□ 0 □ 1 □ 2 □ 3

5. Guilty Feelings:

0. I don't feel particularly guilty. 1. I feel guilty over many things I have done or should have done. 2. I feel quite guilty most of the time. 3. I feel guilty all of the time.

□ 0 □ 1 □ 2 □ 3

6. **Punishment Feelings:**

0. I don't feel I am being punished. 1. I feel I may be punished. 2. I expect to be punished. 3. I feel I am being punished.

□ 0 □ 1 □ 2 □ 3

7. **Self-Dislike:**

0. I feel the same about myself as ever. 1. I have lost confidence in myself. 2. I am disappointed in myself. 3. I dislike myself.

□ 0 □ 1 □ 2 □ 3

NAME: _____

8. Self-Criticalness:

0. I don't criticize or blame myself more than usual. 1. I am more critical of myself than I used to be.

2. I criticize myself for all of my faults. 3. I blame myself for everything bad that happens.

□ 0 □ 1 □ 2 □ 3

9. Suicidal Thoughts or Wishes:

0. I don't have any thoughts of killing myself. 1. I have thoughts of killing myself, but I would not carry them out. 2. I would like to kill myself. 3. I would kill myself if I had the chance.

□ 0 □ 1 □ 2 □ 3

10. Crying:

0. I don't cry any more than I used to. 1. I cry more than I used to. 2. I cry over every little thing.

3. I feel like crying, but I can't.

□ 0 □ 1 □ 2 □ 3

11. Agitation:

0. I am no more restless or wound up than usual. 1. I feel more restless or wound up than usual.

2. I am so restless or agitated, it's hard to stay still. 3. I am so restless or agitated that I have to keep moving or doing something.

□ 0 □ 1 □ 2 □ 3

12. Loss of Interest:

0. I have not lost interest in other people or activities. 1. I am less interested in other people or things than before. 2. I have lost most of my interest in other people or things. 3. It's hard to get interested in anything.

□ 0 □ 1 □ 2 □ 3

13. Indecisiveness:

0. I make decisions about as well as ever. 1. I find it more difficult to make decisions than usual.

2. I have much greater difficulty in making decisions than I used to. 3. I have trouble making any decisions.

□ 0 □ 1 □ 2 □ 3

14. Worthlessness:

0. I do not feel I am worthless. 1. I don't consider myself as worthwhile and useful as I used to. 2. I feel more worthless as compared to others. 3. I feel utterly worthless.

□ 0 □ 1 □ 2 □ 3

15. Loss of Energy:

0. I have as much energy as ever. 1. I have less energy than I used to have. 2. I don't have enough energy to do very much. 3. I don't have enough energy to do anything.

□ 0 □ 1 □ 2 □ 3

NAME: _____

16. Changes in Sleeping Pattern:

0. I have not experienced any change in my sleeping. 1a I sleep somewhat more than usual. 1b I sleep somewhat less than usual. 2a I sleep a lot more than usual. 2b I sleep a lot less than usual. 3a I sleep most of the day. 3b I wake up 1-2 hours early and can't get back to sleep.

□ 0 □ 1 □ 2 □ 3

17. Irritability:

0. I am not more irritable than usual. 1. I am more irritable than usual. 2. I am much more irritable than usual. 3. I am irritable all the time.

□ 0 □ 1 □ 2 □ 3

18. Changes in Appetite:

0. I have not experienced any change in my appetite. 1a My appetite is somewhat less than usual. 1b My appetite is somewhat greater than usual. 2a My appetite is much less than before. 2b My appetite is much greater than usual. 3a I have no appetite at all. 3b I crave food all the time.

□ 0 □ 1 □ 2 □ 3

19. Concentration Difficulty:

0. I can concentrate as well as ever. 1. I can't concentrate as well as usual. 2. It's hard to keep my mind on anything for very long. 3. I find I can't concentrate on anything.

□ 0 □ 1 □ 2 □ 3

20. Tiredness or Fatigue:

0. I am no more tired or fatigued than usual. 1. I get more tired or fatigued more easily than usual. 2. I am too tired or fatigued to do a lot of the things I used to do. 3. I am too tired or fatigued to do most of the things I used to do.

□ 0 □ 1 □ 2 □ 3

21. Loss of Interest in Sex:

0. I have not noticed any recent change in my interest in sex. 1. I am less interested in sex than I used to be. 2. I am much less interested in sex now. 3. I have lost interest in sex completely.

□ 0 □ 1 □ 2 □ 3

Total Score:		**+**		**+**		**=**			**Reviewer:**

PHQ-9 DEPRESSION SCALE

NAME: _____ DATE: ____/ ____ / _____

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

0= Not at all 1= Several days 2= More than half the days 3= 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

TOTAL SCORE:		Reviewer:

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

MEDICATION HISTORY FORM

Patient Name: _____ DOB: _____ / _____ / _____

Medication Brand/ generic name	Highest Dose taken	Start Date	Stop Date or Currently Taking	Helpful or Unhelpful	List any Side Effects
SSRI CLASS					
□ Celexa / citalopram					
□ Lexapro / escitalopram					
□ Luvox / fluvoxamine					
□ Paxil (CR) / paroxetine					
□ Prozac / fluoxetine					
□ Viibryd / vilazodone					
□ Zoloft/ sertraline					
SNRI CLASS					
□ Cymbalta /duloxetine					
□ Effexor (XR) / venlafaxine					
□ Fetzima / levomilnacipran					
□ Pristiq / desvenlafaxine					
□ Savella / milnacipran					

“OTHER” ANTIDEPRESSANTS					
□ Buspar/ buspirone					
□ Desyrel / trazodone					
□ Remeron / mirtazapine					
□ Serzone / nefazodone					
□ Trintellix / vortioxetine					
□ Wellbutrin / bupropion					
“ATYPICAL” / AUGMENTING CLASS					
□ Abilify / aripiprazole					
□ Caplyta / lumateperone					
□ Fanapt / iloperidone					
□ Invega / paliperidone					
□ Latuda / lurasidone					
□ Rexulti / brexpiprazole					
□ Risperdal / risperidone					
□ Saphris / asenapine					
□ Seroquel (XR) / quetiapine					
□ Zyprexa / olanzapine					

TRICYCLIC ANTIDEPRESSANTS					
□ Anafranil / clomipramine					
□ Asendin / amoxapine					
□ Elavil / amitriptyline					
□ Ludiomil / maprotiline					
□ Norpramin / desipramine					
□ Pamelor / nortriptyline					
□ Sinequan / Silenor / doxepin					
□ Surmontil / trimipramine					
□ Tofranil / imipramine					
□ Vivactil / protriptyline					
MAOI					
Emsam / selegiline					
Nardil / phenelzine					
Parnate / tranylcypromine					
MOOD STABILIZERS					
□ Depakote / valproate					
□ Lamictal / lamotrigine					
□ Lithobid / Eskalith / lithium					
□ Lyrica / pregabalin					
□ Neurontin / gabapentin					
□ Tegretol / carbamazepine					

STIMULANTS					
□ Adderall (XR)/ Adderall / Amphetamine salts (others) names)					
□ Focalin / desmethylphenidate					
□ Ritalin / Concerta / Methlyphenidate / (other) names)					
□ Vyvanse / lisdexamfetamine					
□Other					
□ **iv Ketamine or Spravato**					
OTHER? (Write in)					
□					
□					

I hereby attest that I have completed the above TMS Therapy Registration Form and that the information provided is true and accurate to the best of my knowledge. I authorize Novus TMS to submit a prior authorization request to my insurance based on the above information and my requested medical records.

_____ Date of Birth: _____/_____/_____
Patient Printed Name

_____ Date:_____
Signature of Patient

Novus Neurology | Psychiatry | TMS

2201 Jack Warner Parkway, Tuscaloosa, AL 35401
Phone (205) 523-5618 FAX (205) 860-6332

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I understand that Novus TMS is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose information, and the recipient (s) of that information. I specifically authorize any current employee or owner of Novus TMS, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the step set forth below.

I _____ authorize that Novus TMS to:

_____ Release to:
__X__ Obtain from: **Pharmacy**
Facility/MD Name:_____
Address:_____
Phone: _____Fax:_____

Date range requested: __X___ all past dates _____date range: from _____to _____

Description of Information to be used or disclosed:

___ The patient's entire medical record
___ Labs
___ Imaging Report(s)_____ mail CD of images to address above
_X__ Other (specify):____Medication Record_____

For the purpose of:

__X_ Evaluation/assessment and/or continuation of care
____ Other (specify):_____

Fax all requested records to: (205) 860-6332

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released). All revocations must be sent to Novus TMS to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

This consent will automatically expire one (1) year after the date of my signature as it appears below.

_____ Date of Birth:_____
Patient Printed Name

_____ Date:_____
Signature of Patient

Novus Neurology | Psychiatry | TMS

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I _____ authorize that Novus TMS to:

_____ Release to:
__X__ Obtain from: **Psychotherapist Provider**
Facility/Provider Name:_____
Address:_____
Phone: _____Fax:_____

Date range requested: __X___ all past dates _____date range: from _____to _____

Description of Information to be used or disclosed:

___ The patient's entire medical record
___ Labs
___ Imaging Report(s)_____ mail CD of images to address above
_X_ Other (specify): _____

- ☑ Modality of Therapy
- ☑ Provider Name
- ☑ Start Date - Stop Date
- ☑ Current Frequency
- ☑ Total Number of Sessions

For the purpose of:

__X_ Evaluation/assessment and/or continuation of care
__X__ Other (specify):_Transcranial Magnetic Stimulation Therapy_____

Fax all requested records to: (205) 860-6332

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released). All revocations must be sent to Novus TMS to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

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_____ Date of Birth:_____
Patient Printed Name

_____ Date:_____
Signature of Patient

Novus
Neurology | Psychiatry | TMS

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2201 Jack Warner Parkway, Tuscaloosa, AL 35401
Phone: (205) 523-5618 Fax: (205) 860-6332 www.novusneuro.com

Provider: _____

Patient Name and DOB: _____

Psychotherapy Intake: _____

Termination: _____

Treatment Plan: _____

Recent Appointment: _____

Appointment History: _____

Diagnosis: _____

Psychotherapy Intake # _____

Individual Therapy Sessions: _____

Treatment Modality: _____

Date: _____

Signature: _____