



## TMS Consultation Packet

Patient Name: \_\_\_\_\_ Consult Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

\*Cell Phone: \_\_\_\_\_ \*Alt Phone: \_\_\_\_\_

Email: \_\_\_\_\_

DL #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred By: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Responsible Party Info: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

DL #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone#: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance:

Do you have medical insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

# Lakeview TMS Center Patient History

PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

## Past Medical History

### Medication Allergies Major Medical Illnesses

- No  Yes If yes, please list with reaction: \_\_\_\_\_
- Head Trauma  No  Yes If yes, explain: \_\_\_\_\_
- Seizure Disorder  No  Yes If yes, type: \_\_\_\_\_
- Asthma  No  Yes \_\_\_\_\_
- Heart Problems  No  Yes If yes, explain: \_\_\_\_\_
- Diabetes  No  Yes \_\_\_\_\_
- High Blood Pressure Thyroid Problems  No  Yes \_\_\_\_\_
- Cholesterol Problems  No  Yes If yes, explain: \_\_\_\_\_
- Cancers/Radiation/Cherne  No  Yes If yes, explain: \_\_\_\_\_
- Repeated ear infections  No  Yes If yes, explain: \_\_\_\_\_
- Any birth defects  No  Yes If yes, explain: \_\_\_\_\_
- Fainting  No  Yes If yes, explain: \_\_\_\_\_
- Chest pain  No  Yes If yes, explain: \_\_\_\_\_
- Irregular heart beats  No  Yes If yes, explain: \_\_\_\_\_
- Liver disease  No  Yes If yes, explain: \_\_\_\_\_
- Kidney disease  No  Yes If yes, explain: \_\_\_\_\_
- Other  No  Yes If yes, explain: \_\_\_\_\_
- Hospitalizations  No  Yes If yes, explain: \_\_\_\_\_

Operations  No  Yes If yes, explain: \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_

Blood work in past year  No  Yes If yes, when and results: \_\_\_\_\_

Current Primary Care Physician Name: \_\_\_\_\_ Last Seen: \_\_\_\_\_

### Family History \_\_\_\_\_

(Disorders present in ANY BLOOD RELATIVE of the patient- specify who has the disorder)

#### Medical Disorders

- Heart Problems  No  Yes If yes, explain: \_\_\_\_\_
- Sudden Death  No  Yes If yes, explain: (Unknown cause of death prior to 40) \_\_\_\_\_
- Seizures  No  Yes If yes, explain: \_\_\_\_\_
- Diabetes  No  Yes If yes, explain: \_\_\_\_\_
- High Blood Pressure  No  Yes If yes, explain: \_\_\_\_\_
- Thyroid  No  Yes If yes, explain: \_\_\_\_\_
- Asthma  No  Yes If yes, explain: \_\_\_\_\_
- Cholesterol Problems  No  Yes If yes, explain: \_\_\_\_\_
- Cancers  No  Yes If yes, explain: \_\_\_\_\_
- Glaucoma  No  Yes If yes, explain: \_\_\_\_\_
- Others  No  Yes If yes, explain: \_\_\_\_\_

#### Psychiatric Disorders

- Anxiety disorder  No  Yes If yes, explain: \_\_\_\_\_
- Bipolar Disorder  No  Yes If yes, explain: \_\_\_\_\_
- Depression  No  Yes If yes, explain: \_\_\_\_\_
- Anorexia/Bulimia  No  Yes If yes, explain: \_\_\_\_\_
- Drug Problems  No  Yes If yes, explain: \_\_\_\_\_
- Alcohol Problems  No  Yes If yes, explain: \_\_\_\_\_
- Mental Retardation  No  Yes If yes, explain: \_\_\_\_\_
- Learning disorder  No  Yes If yes, explain: \_\_\_\_\_
- Dyslexia  No  Yes If yes, explain: \_\_\_\_\_
- Schizophrenia  No  Yes If yes, explain: \_\_\_\_\_
- Completed Suicide  No  Yes If yes, explain: \_\_\_\_\_
- ADHD  No  Yes If yes, explain: \_\_\_\_\_
- Autism  No  Yes If yes, explain: \_\_\_\_\_
- OCD  No  Yes If yes, explain: \_\_\_\_\_
- Other  No  Yes If yes, explain: \_\_\_\_\_



# Lakeview TMS Center Patient History

PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

## Past Psychiatric History

Current Providers:  No  Yes  
Therapist:

Psychiatrist:

Past Providers:  No  Yes

Therapist:

Psychiatrist:

Psychological/IQ Testing done  No  Yes; If Yes: when and what where the results

Inpatient Psychiatric Hospitalizations:  No  Yes; If Yes: detail when, where, and why

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Day Treatment Hospitalizations:  No  Yes; If Yes: detail when, where, and why

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Suicide Attempts  No  Yes; If Yes: detail when, method of attempt, and if medical treatment was sought/ received

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Substance Use/ Abuse/ Dependence (Curren/Past):  No  Yes

Nicotine  Alcohol  Cocaine  Marijuana  Opiates (Heroin, etc.)  Prescription drugs  IV Drugs  Other \_\_\_\_\_

- |       |                     |                          |                         |   |
|-------|---------------------|--------------------------|-------------------------|---|
| _____ | Use Per Week: _____ | Date of First Use: _____ | Date of Last Use: _____ | Withdrawal Symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| _____ | Use Per Week: _____ | Date of First Use: _____ | Date of Last Use: _____ | Withdrawal Symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| _____ | Use Per Week: _____ | Date of First Use: _____ | Date of Last Use: _____ | Withdrawal Symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| _____ | Use Per Week: _____ | Date of First Use: _____ | Date of Last Use: _____ | Withdrawal Symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| _____ | Use Per Week: _____ | Date of First Use: _____ | Date of Last Use: _____ | Withdrawal Symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| _____ | Use Per Week: _____ | Date of First Use: _____ | Date of Last Use: _____ | Withdrawal Symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes |

List ALL Current Medications- including herbal, supplements, over the counter	Dose	Frequency	Route

Who has been prescribing the above medications?

## TMS THERAPY CONTRAINDICATIONS

Please read through the list below and check any that apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Aneurysm clips or coils                             | <input type="checkbox"/> Implanted insulin pump                |
| <input type="checkbox"/> Carotid or cerebral stents                          | <input type="checkbox"/> Magnetically programmable shunt valve |
| <input type="checkbox"/> DBS electrodes                                      | <input type="checkbox"/> Radioactive seeds                     |
| <input type="checkbox"/> Vagus nerve stimulator                              | <input type="checkbox"/> Staples, sutures                      |
| <input type="checkbox"/> Magnetically activated dental implant               | <input type="checkbox"/> VeriChips Microtransponder            |
| <input type="checkbox"/> Cochlear otologic implants                          | <input type="checkbox"/> Wearable physiologic monitors         |
| <input type="checkbox"/> CSF shunt   | <input type="checkbox"/> Bone Growth stimulators               |
| <input type="checkbox"/> Ferromagnetic ocular implants                       | <input type="checkbox"/> Portable Glucose Monitors             |
| <input type="checkbox"/> Wearable infusion pumps                             | <input type="checkbox"/> Hearing aids                          |
| <input type="checkbox"/> Permanent makeup <30 from coil                      | <input type="checkbox"/> Removable dentures/bridgework         |
| <input type="checkbox"/> Cardiac Pacemakers, ICDs                            | <input type="checkbox"/> Metallic devices implanted in head    |
| <input type="checkbox"/> Wearable cardioverters defibrillator (WCD)          | <input type="checkbox"/> Metallic devices implanted in neck    |
| <input type="checkbox"/> Cardiac stents, filters, valves                     |  |
| <input type="checkbox"/> Pellets, bullets, fragments above the shoulder line | <input type="checkbox"/> Diagnosis of Seizure Disorder         |

**Objects that can be affected by the magnetic field, such as jewelry or hair barrettes, must be removed before treatment to avoid potential harm. After these items are removed, TMS is no longer contraindicated for these patients.**

**Please initial** if none of the above contraindications apply to you.

\* I am aware that due to titanium implants that there is an increased risk for side effects during treatment.

\* **I have read, understood and agree that all provided information is true and accurate.** \*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

CHECK ANY MEDICATIONS TAKEN.

PROVIDE MAXIMUM DOSAGE, TIME FRAME WITH DATES, AND IF ANY SIDE EFFECTS OCCURRED.

**ANTIDEPRESSANT AND AUGMENTING AGENTS**

GENERIC NAME	BRAND NAME	MAX DOSING	DATE RANGE MONTH & YEAR	SIDE EFFECTS Or WHY DISCONTINUED
Citalopram	Celexa	20-40mg		
Escitalopam	Lexapro	10-20mg		
Fluoxetine	Prozac	20-80mg		
Paroxetine	Paxil	20-60mg		
Paroxetine XR	Paxil CR	25-75mg		
Sertraline	Zoloft	50-200mg		
Fluvoxamine	Luvox	50-300mg		
Fluvoxamine CR	Luvox CR	100-300mg		

Desvenlafaxine	Pristiq	50-100mg		
Duloxetine	Cymbalta	60-120mg		
Venlafaxine	Effexor	75-225mg		
Venlafaxine XR	Effexor XR	75-225mg		
Levomilnacipran	Fetzima	40-120mg		

Bupropion	Wellbutrin	100-450mg		
Bupropion SR	Wellbutrin SR	200-400mg		
Bupropion XL	Wellbutrin XL	150-450mg		
Mirtazapine	Remeron	15-45mg		
Trazodone	Desyrl	150-600mg		
Vilazodone	Viibryd	20-40mg		
Vortioxetine	Trintellix	10-20mg		
Esketamine	Spravato	56 or 84		
Brexanolone	Zulresso	60 hr infusion		



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Phenelzine	Nardil	45-90mg			
Segeline	Emsam	10mg			
Tranlycypromine	Parnate	30-60mg			

Augmentation medications	Abilify, Rexulti, Seroquel XR Vraylar Caplyta				
Lithium					
L-Methylfolate	Deplin				



# LAKEVIEW TMS CENTER

## ELECTRONIC COMMUNICATION CONSENT

### 1. RISK OF USING E-MAIL, TEXT MESSAGES AND VOICEMAIL

Lakeview TMS Center (Providers/Staff) offers patients the opportunity to communicate by e-mail, text messages or voicemail. Transmitting patient information by email, text messages or voicemail, however, has a number of risks that patients should consider before using e-mail, text messages or voicemail. These include, but are not limited to, the following risks: a) E-mail, text messages or voicemail can be circulated, forwarded, and stored in numerous paper and electronic files. b) E-mail, text messages or voicemail can be immediately broadcast worldwide and be received by many intended and unintended recipients. c) E-mail, text messages or voicemail senders can easily misaddress an e-mail, text messages or voicemail. d) E-mail, text messages or voicemail are easier to falsify than handwritten or signed documents. e) Backup copies of e-mail, text messages or voicemail may exist even after the sender of the recipient has deleted his or her copy. f) Employer and on-line services have a right to archive and inspect e-mails or text messages transmitted through their systems. g) E-mail, text messages or voicemail can be intercepted, altered, forwarded, or used without authorization or detection. h) E-mail, text messages or voicemail can be used to introduce viruses into computer systems. i) E-mail, text messages or voicemail can be used as evidence in court.

### 2. CONDITIONS FOR THE USE OF E-MAIL, TEXT MESSAGES AND VOICEMAIL

Lakeview TMS Center will use reasonable means to protect the security and confidentiality of e-mail, text messages or voicemail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail, text messages or voicemail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider’s intentional misconduct. Thus, patients must consent to the use of e-mail, text messages or voicemail for patient information. Consent to the use of e-mail, text messages or voicemail includes agreement with the following conditions: a) All e-mails or text messages to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient’s medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails or text messages. b) Provider may forward e-mails or text messages internally to Provider’s staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails or text messages to independent third parties without the patient’s prior written consent, except as authorized or required by law. c) Although Provider will endeavor to read and respond promptly to an e-mail, text messages or voicemail from the patient, Provider cannot guarantee that any particular e-mail, text messages or voicemail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail, text messages or voicemail for medical emergencies or other time-sensitive matters. d) If the patient’s email or text messages requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient’s responsibility to follow up to determine whether the intended recipient received the e-mail, text messages or voicemail and when the recipient will respond. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, text messages or voicemail. e) The patient is responsible for protecting his/her password or other means to access to e-mail, text messages or voicemail. Provider is not liable for breaches of confidentiality caused by the patient or third party. f) Provider shall not engage in e-mail, text messages or voicemail communication that is unlawful, such as unlawfully practicing medicine across state lines. g) It is the patient’s responsibility to follow up and/or schedule and appointment if warranted.

### 3. INTRUCTIONS TO COMMUNICATE BY E-MAIL, TEXT MESSAGES AND Voicemail

The patient shall: a) Limit or avoid use of his/her employer’s computer. b) Inform Provider of changes in his/her e-mail address or text messages in writing. c) Put the patient’s name in the body of the e-mail, text messages or voicemail. d) Include the category of the communication in the e-mail’s subject line or text messages, for routing purposes (e.g., billing question). e) Review the e-mail, text messages or voicemail to make sure it is clear and that all relevant information is provided before sending to Provider. f) Inform Provider that the patient received an e-mail, text messages or voicemail from Provider. g) Take precautions to preserve the confidentiality of e-mails or text messages, such as using screen savers and safeguarding his/her computer password. h) Withdraw consent only by written communication to Provider. i) If contact information changes you are fully responsible and must provide a new form and inform Rockwall Psychiatry & Associates

### 4. PATIENT/LEGAL GUARDIAN ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have fully read, understand and agree to this consent form. I voluntarily agree to sign this agreement electronically and be legally bound. I understand the risks associated with the electronic communication of e-mail, text messages and voicemail between Lakeview TMS Center and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail, text messages and voicemail. I understand potential risks/ benefits and agree to allow Lakeview TMS Center to send email and or text communication or voicemail regarding appointments or any part of my treatment. Any questions I may have had were answered. I can revoke this consent in writing at any time to my provider. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider’s office directly or to the existing emergency 911 services in my community.

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Full Name of person signing form: \_\_\_\_\_ Date: \_\_\_\_\_

## TELE HEALTH COMMUNICATION CONSENT

**1. Introduction**

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. Telehealth involves the use of electronic communications to enable health care providers to provide patient care through the means of live two-way audio and/or video. The purpose of this form is to obtain your consent to participate in a Telehealth consultation for various psychiatric/ medical conditions/illnesses. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, Medical images, Live two-way audio and/or video and Output data from medical devices and sound and video files.

**2. Confidentiality**

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth consultation.

**3. Nature of Telehealth Consent**

During the Telehealth consultation: Details of your psychiatric/ medical history, examinations and tests will be discussed using interactive video and/or audio, A virtual examination may take place, Other medical professionals such as nurse practitioners, assistants and/or Scribes may be present during the visit to assist the provider and Photographs may be taken of you during the service. In an emergency, it is the responsibility of the Telehealth provider to direct the patient to emergency medical/psychiatric services, such as an emergency room. The Telehealth provider may also discuss and advise with the patient's local provider (if applicable). The Telehealth providers responsibility will end upon the termination of the Telehealth connection. I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records and copies of medical records.

**4. Possible Risks**

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. The session may be discontinued by the patient and/or the provider if the video conference connection is not adequate for the situation. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge an despite taking reasonable measures. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

**5. Billing and Payment**

Lakeview TMS Center is a fee for service psychiatric office and provider do not participate as in network with insurance plans. Your appointment payment is due in full at prior to your appointment. It is your responsibility to contact your insurance company to verify your out of network rates of reimbursement. We classify your appointment as self-pay and you are able with commercial insurance to file for out of network benefits EXCEPT Medicare. You MAY NOT file with medicare and must inform us if you have medicare coverage. Telehealth services may not be covered by all insurance plans. Non-covered Telehealth visits will be the patient's full responsibility.

**6. Your Rights & Responsibilities**

You may withhold or withdraw consent to the Telehealth consultation at any time in WRITING without affecting your right to future care or treatment or risking the loss or withdraw of any program benefits to which you would otherwise be entitled. I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that she is my healthcare provider. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit I understand that electronic communication cannot be used for emergencies or time sensitive matters. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendation including further diagnostic/psychological testing, lab testing, or an in-office visit. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I Consent to Telehealth \*

By checking the above box and signing below, you are certifying you have read, understand and agree to all conditions indicated on the telepsychiatry consent and agree for Lakeview TMS Center providers to utilize this modality to provide your psychiatric care and management of treatment.

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_ First and Last Name of person signing form: \_\_\_\_\_

Lakeview TMS Center 2249 Ridge Road, Rockwall, TX 75087  
469-402 -7867 or fax 469-402-7868