BRANDYWINE VALLEY TMS
JACK CASTRO MD

2300 Pennsylvania Ave., Ste 4C-1
Wilmington, DE 19806
P 302-635-1710 | Fax 570-221-6246

Dear Patient:

Thank you for choosing Brandywine Valley TMS for the treatment of your condition. The following information has been prepared so that you may have a clear understanding of the practice policies concerning fees, insurance and confidentiality.

Most insurance networks require a prior authorization before you begin treatment.

We have designed this **TMS Registration Form** based on the information that will be required by most insurance companies. So, while we understand no one enjoys filling out these types of forms, we ask that you please be as thorough as possible and take the necessary time to complete it or your insurance will most likely decline payment for your treatment.

Most insurances will require the following criteria are met in order for them to approve TMS for your:

- A diagnosis of depression (moderate to severe)
- A minimum of 2-4 antidepressant trials
- A history of psychotherapy (therapist, counselor, group therapy, outpatient therapy, extended visits with psychiatrist, or psychologist)
- PHQ-9 (depression screening) score > or = 18

We thank you for taking the time to complete our TMS Registration Form and look forward to helping you to achieve long-term relief from your condition. If you need assistance completing this form, please contact our staff so we may clarify any questions you may have.

Sincerely,

Jack Castro, MD
Brandywine Valley TMS

TMS REGISTRATION FORM

BASIC INFORMATION:

Date: _____

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

Gender: _____ Patient's SSN: _____ *Used for Insurance Reasons*

Mailing Street & Apt #: _____

I understand that by providing this address, statements and necessary forms may be mailed to the address provided.

City: _____ State: _____ Zip Code: _____

□ Address has been verified by USPS.com/zip4 (Office Use)

Marital Status of Client: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

CONTACT INFORMATION:

Unless otherwise specified below, by providing phone numbers and emails you are giving permission for Brandywine Valley TMS to leave voice mails and contact you via email. For additional information on email communication and privacy, please see our privacy policy.

Cell: *(Default)* _____ Home: _____ Work: _____

Email Address: _____

APPOINTMENT REMINDERS:

Appointment reminders may be provided by our Electronic Medical Records (EMR) system. When your appointment is scheduled, we will confirm your appointment 2-5 days prior to your appointment time. By completing this section, you acknowledge that information through email/text/voicemail is not necessarily secure and we cannot guarantee that someone else will not access information regarding your appointment through these means.

☐ I prefer not to receive reminders

To receive reminders, please check the box that applies:

☐ Text or Call or Email ☐ Email Only ☐ Text Only ☐ Call Only ☐ Voicemail messages OK

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Client: _____

Phone Number: _____ May we leave messages with this person: ☐ Yes ☐ No

ADDITIONAL CONTACT INFORMATION:

Primary Care Doctor Name: _____ Phone: _____

Patient Initials: _____

TMS REGISTRATION FORM

Psychiatrist Name: _____ Phone: _____

May we contact this person regarding your care here? ☐ Yes ☐ No

Therapist/Counselor Name: _____ Phone: _____

May we contact this person regarding your care here? ☐ Yes ☐ No

FINANCIAL RESPONSIBILITY AGREEMENT:

Brandywine Valley TMS reserves the right to charge for services rendered by any practitioner or provider employed by our practice for any services rendered at our clinic(s). Please see the different sections below to indicate how payment will be collected and services will be billed. For any questions regarding this section, please contact our office at 302 635 1710.

Payments and Billing:
*If you are 18 years of age or older, unless other signatures are provided, statements and financial responsibility will default to you.

Use of Insurance Plans:
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 pre-authorization and will communicate this to you. You understand that benefit checks and pre-authorization is 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 denies paying claims, you may still be responsible for payment of services provided. We make every effort to obtain pre-authorization for services prior to treatment and it is your responsibility to notify our offices of any change in insurance.

If the Insurance Holder is different than that of the patient receiving services, please provide the following information:

Full Name: _____ Relationship to Patient: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Employer: _____

Patient Initials: _____

TMS REGISTRATION FORM

CANCELLATION POLICY:

By signing this form, you acknowledge that by scheduling an appointment, we reserve time specifically for you. This time is set aside and prevents others from scheduling during your reservation. We request a minimum of 24-hour notice for any cancellations or reschedules. Insurance does not cover missed appointments. Therefore, we allow up to three (3) missed appointments with proper notification as indicated above, and any appointment missed beyond the third one will be charged a $50 cancellation. Please be aware that a failure to receive a reminder does not waive this cancellation fee. You are still responsible to remember your appointment dates and times.

SPECIAL CIRCUMSTANCES:

We make every effort possible to respect the wishes of our clients. However, Brandywine Valley TMS is not responsible for maintaining financial arrangements made between separated or divorced parents or couples under any circumstances. If there is a financial agreement between such parties, we respect your privacy and require that you manage those arrangements.

For financial responsibility in these types of cases, the person whose signature is on file on the registration paperwork is deemed the party responsible for payment. We cannot acknowledge financial responsibility for a party who is not present to agree to the terms provided. *(Statement can be provided to the responsible party, upon request, for proof of payment to other parties).*

PAST DUE BALANCES:

By signing this document, you acknowledge that unpaid balances of 30 days past due status may be subject collection agencies. If balances are not paid, we reserve the right to utilize collection agency services. Payments are expected at the time of service; however, if a balance is due, it is due within 30 days and may be accepted in person or by mail via cash, credit/debit card or health savings account card.

CONSENT TO TREATMENT:

By signing this document, you agree to the following statements:

I agree to participate in treatment and understand that a positive outcome cannot be guaranteed. I understand that positive outcomes are based on my compliance with treatments. I also understand that TMS therapy is a treatment modality that does not guarantee symptom remission nor a cure for my condition.

CONFIDENTIALITY AND PRIVACY:

I have read and agreed to the Privacy Notice (HIPAA Statement) provided to me. I understand that I can obtain a printed copy from the staff and can ask for clarification on any policies stated in it.

I (print name) _____ have read and understand the above conditions of this document and agree with them. I have asked any questions I am concerned with and understand the policies outlined above.

Patient Printed Name: _____Date: _____

Patient Signature: _____

TMS REGISTRATION FORM

INSURANCE INFORMATION:

Name of Insurance: _____ ID#: _____ Group#: _____

Subscribers Name: _____ Relationship to Patient: _____

Other Numbers of Insurance Card: _____ Pre-Auth Phone#: _____

SECONDARY INSURANCE:

Name of Insurance: _____ ID#: _____ Group#: _____

Subscribers Name: _____ Pre-Auth Phone#: _____

WHO REFERRED YOU FOR TMS THERAPY:

Name of provider who referred you: _____ ☐ Psychiatrist ☐ Therapist ☐ Primary Doctor Referral

Source Phone#: _____ May we contact: ☐ Yes ☐ No Do You

have a diagnosis of Major Depression: ☐ Yes ☐ No

CURRENT PSYCHIATRIC MEDICATIONS:

Are you currently taking antidepressant medications: ☐ Yes ☐ No

Please list all your current medications:

Medication	Dose	Start Date	Stop Date	Reason for Discontinuation

Are you currently taking or have you ever taken any medication for a seizure disorder: ☐ Yes ☐ No
If so, what medication: _____ Start Date: _____ Stop Date: _____

In the past 6 months, have you used alcohol, illicit drugs, or abused benzodiazepines: ☐ Yes ☐ No

If so, do you drink ETOH on a daily or weekly basis? ☐ Yes ☐ No How much per day? ___

If you use illicit drugs, which ones: ☐ Marijuana ☐ Opiates ☐ Cocaine ☐ Hallucinogens ☐ Other

If you abuse benzodiazepines, which ones: _____

How many Mg per day: _____

Patient Initials: _____

TMS REGISTRATION FORM

FOR TMS THERAPY INSURANCE AUTHORIZATION:

For insurance pre-authorization, insurance companies typically require the following, which is the minimum requirements for pre-authorization to be submitted:

- A confirmed diagnosis of Major Depressive Disorder or Treatment Resistant Depression, Obsessive Compulsive Disorder (OCD), or Bipolar Depression (BD)
- Prior trials of antidepressant medications with little or no benefit from symptoms OR medication discontinuation due to side effects (each insurance requires a specific number of antidepressant trials – for example, Medicare requires a minimum of two (2) antidepressants with little or no benefit or inability to continue medication due to side effects, other insurances require a history of 3-4 antidepressants during the current episode.
- No history of seizures
- A history of psychotherapy with little or no benefit (physician, therapist, counselor, outpatient mental health visit, etc.)
- No TMS Therapy contraindications
- Insurance requires medical record documentation of all of the above, including other qualifying information, in order to obtain prior authorization for TMS therapy services. Brandywine Valley TMS will request your medical records from your health care providers in order to have this information on file for pre-authorization.

We will submit a prior authorization to your insurance upon receipt of all required documentation from you and your current or previous health care providers.

Do you provide permission for Brandywine Valley TMS to submit a prior authorization request to your insurance provider for TMS therapy (transcranial magnetic stimulation) services and/or for services to be provided to you by one of our physicians or healthcare providers. Please choose:

☐ Yes ☐ No

I have read or have been made aware of the following:

- HIPPA Notice and Patient Privacy Acts
- TMS Therapy Contraindications
- TMS Therapy Hearing Protection Waiver
- Indications for and any side effects of TMS Therapy, including an explanation of TMS Therapy for the treatment of major depression or other diagnosis that I may be receiving TMS Therapy for.
- I have had all of my questions and/or concerns answered

I also understand that TMS therapy treatment sessions emit a loud ticking noise, similar to that of a magnetic resonance imaging (MR). There are no reports of hearing loss; however, ear plugs are available and recommended to wear during each treatment session. I understand I may elect to decline wearing the ear plugs. I also agree to hold Brandywine Valley TMS and each of its employees and physicians harmless from any liability related to any hearing problems during or after my treatment regardless of whether I elect or decline to wear earplugs.

A parent signature is required for all patients under the age of 18. A guardian signature is required if the patient has a guardian.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____

Patient Initials: _____

TMS REGISTRATION FORM

Have you ever been diagnosed with:

Bipolar Disorder ☐ Yes ☐ No

OCD ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No

Substance Use Disorder ☐ Yes ☐ No

PTSD ☐ Yes ☐ No

Eating Disorder ☐ Yes ☐ No

Seizure Disorder ☐ Yes ☐ No

Any other Neurological Disorder (dementia, Alzheimer's, stroke, autism, epilepsy) ☐ Yes ☐ No

Current symptoms:

☐ Loss of interest / low motivation

☐ Feeling down, depressed, hopelessness

☐ Insomnia or sleeping too much

☐ Poor or increased appetite

☐ Low self-esteem

☐ Poor concentration

☐ Sluggishness or restlessness

☐ Suicidal ideation

☐ Irritability

☐ Anxiety

☐ Social isolation

☐ Crying spells

Have you participated in outpatient psychotherapy? ☐ Yes ☐ No; Where/with whom: _____

When (month & year): _____ How long: _____ How often (weekly, monthly): _____

Do you have a psychotherapist or counselor? ☐ Yes ☐ No; Who: _____

How often do you see your psychotherapist? _____

Has psychotherapy helped to resolve depression symptoms: ☐ Yes ☐ No

What types of psychotherapy have you tried in the past or are currently receiving?

Please check all previous types of psychotherapy:

☐ Cognitive Behavioral Therapy (CBT); ☐ Client Centered Therapy (CCT/PCT) ☐ Existential Therapy ☐ Psychoanalytic or Psychodynamic Therapy ☐ Dialectical Behavior Therapy (DBT) ☐ Interpersonal Psychotherapy (IPT) ☐ Mindfulness Therapy; ☐ Group Therapy; ☐ Other _____

Have you been hospitalized for depression in the past? ☐ Yes ☐ No; Hospital: _____
When (month & year): _____

Have you had any of the following: ☐ TMS; ☐ ECT; ☐ Vagus Nerve Stimulator

Do you currently have a Vagus Nerve Stimulator? ☐ Yes ☐ No

If you have had TMS previously: Name of clinic, doctor & location: _____

When did you start TMS (month & year)? _____ When did you stop TMS (month & year): _____

Did you have greater than 50% improvement in your symptoms? ☐ Yes ☐ No

Age you were first diagnosed with depression: _____

Have you ever been in remission from depression? ☐ Yes ☐ No
If so during what time frame? _____

I, _____attest that I have completed the above assessment and that the information provided is true and accurate to the best of my knowledge. I authorize Brandywine Valley TMS to submit a pre-authorization request to my insurance based on the above information and my requested medical records if necessary.

Patient Printed Name: _____Date: _____

Patient Signature: _____

BRANDYWINE VALLEY TMS
JACK CASTRO MD

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Patient Full Name: _____ **Date**: _____

TMS THERAPY EXCLUSION CRITERIA

TMS Therapy is contraindicated for use in some situations as identified below. The TMS therapy system treatment coil produces strong, pulsed magnetic fields, which can affect certain implanted devices or objects. The magnetic field strength diminishes quickly with increasing distance from the coil. Within 30 cm of the face of the treatment coil, the peak magnetic field can be greater than 5 Gauss, which is the recommended static magnetic field exclusion level for many electronic devices.

TMS Therapy is contraindicated for use in patients who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm of the treatment coil. Removable objects that may be affected by the magnetic field should be removed before treatment to prevent possible injury. (Examples include jewelry/hair barrettes, etc.). Once these objects are removed TMS is not contraindicated for these patients.

Please complete the following form prior to the start of TMS treatment. If you have selected any of the boxes under the Contraindicated Section, then TMS therapy is contraindicated, and therefore would not be a viable treatment option.

In some instances, patients may present with questions regarding permanent tattoos or make-up, permanent mouth retainers, braces, and any other types of metal within or near the head that are not listed as a TMS Contraindication, and that may or may not cause an adverse event, side effect, or any other complication related to receiving TMS therapy. While we are certain of specific contraindications (which are listed on the Confirmed Contraindications Form), there has not been significant research to specifically indicate whether transcranial magnetic stimulation (TMS) will cause any adverse reaction or event or side effect for any situation or circumstance that is NOT listed on our Contraindication Form.

By signing below, you acknowledge the Confirmed Contraindications for TMS Therapy and agree that you do not have any of the Confirmed Contraindications indicated on the TMS Therapy Contraindications Form. You also acknowledge that while permanent tattoos and make-up, permanent retainers, braces, and other non-ferromagnetic materials in or around the head are not listed as a contraindication, there is still a potential for a negative reaction, side effect, or adverse outcome; and you agree to continue with TMS therapy treatment and hold Brandywine Valley TMS and any of its employees or affiliates harmless of any adverse outcome, event, or side effect that may occur as a result of receiving TMS therapy.

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

CONFIRMED CONTRAINDICATIONS FOR TMS THERAPY - Please check all that apply to you:

☐ Cochlear implants
☐ Implanted electrodes/simulators
☐ Aneurysm clips/coils
☐ Pacemaker
☐ Implanted Cardioverter Defibrillator (ICD)
☐ Wearable Cardioverter Defibrillator (<30cm from coil)
☐ Infusion pump
☐ Implanted insulin pump
☐ Stents, filters, heart valves
☐ Magnetically programmable shunt valves
☐ VeriChip microtransponder
☐ Previously removed ICD
☐ Stents
☐ Device leads
☐ Deep brain stimulator
☐ Vagus nerve stimulators
☐ Magnetically activated dental implants
☐ Ferromagnetic ocular implants
☐ Cerebral Spinal Fluid Shunt
☐ Pellets, bullets, fragments (<30cm from coil)
☐ Facial tattoos w/metallic ink
☐ EEG electrodes
☐ DBS electrodes
☐ Metallic devices implanted in head
☐Other: Please specify_____

If you have checked any of the above, then TMS therapy is contraindicated as a treatment option and is not recommended as a safe treatment for you.

Contraindicated Removable Devices

☐ Holter monitor
☐ Bone growth stimulators
☐ Portable glucose monitor
☐ Hearing aids
☐ Eyeglasses
☐ Cell phone
☐ Headphones/MP3 players
☐ Staples, sutures
☐ Radioactive seeds
☐ Cervical fixation device

Patient Printed Name: _____ Date: _____

Patient Signature: _____

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JACK CASTRO MD

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Patient Name:
Date:

MEDICATION HISTORY CHECKLIST

Please review all pages and complete to the best of your ability. Below is a list of common medications that are used to treat depression. Please check the medications you have been treated with in the past or that you are actually taking now. Provide estimated start and stop dates if applicable.

SSRI (Selective Serotonin Reuptake Inhibitors)

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Citalopram	Celexa			
Escitalopram	Lexapro			
Fluoxetine	Prozac			
Fluvoxamine	Luvox			
Fluvoxamine CR	Luvox CR			
Paroxetine	Paxil			
Paroxetine CR	Paxil CR			
Sertraline	Zoloft			
Vortioxetine	Trintellix			
Vilazodone	Viibryd			

SNRI (Serotonin-Norepinephrine Reuptake Inhibitors)

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Desvenlafaxine	Pristiq			
Duloxetine	Cymbalta			
Venlafaxine	Effexor			
Venlafaxine XR	Effexor XR			
Levomilnacipran	Fetzima			
Milnacipran	Savella			

TCA (Tricyclic Antidepressants)

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Amitriptyline	Elavil			
Clomipramine	Anafranil			
Desipramine	Norpramin			
Doxepin	Sinequan			
Imipramine	Tofranil			
Maprotiline	Ludiomil			
Nortriptyline	Pamelor			
Trimipramine	Surmontil			
Protriptyline	Vivactil			

NDRI (Norepinephrine-Dopamine Reuptake Inhibitors) / Atypical Antidepressants

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Bupropion	Wellbutrin			
Bupropion XL	Wellbutrin XL			
Bupropion SR	Wellbutrin SR			
Mirtazapine	Remeron			

MAOI (Monoamine Oxidase Inhibitors)

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Phenelzine	Nardil			
Selegiline	Emsam			
Tranylcypromine	Parnate			

SARI (Serotonin Antagonist and Reuptake Inhibitor)

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Desyrel	Trazodone			
Vortioxetine	Trintellix			
Nefazodone	Serzone			

Mood Stabilizers & Antipsychotics

Generic Name	Brand Name	Dose	Approximate Date Started	Approximate Date Stopped
Aripiprazole	Abilify			
Eskalith	Lithium			
Carbamazepine	Tegretol			
Carbamazepine XR	Equetro			
Divalproex	Depakote			
Lamotrigine	Lamictal			
Brexpiprazole	Rexulti			
Oxcarbazepine	Trileptal			
Cariprazine	Vraylar			
Quetiapine	Seroquel			
Lurasidone	Latuda			
Olanzapine	Zyprexa			
Ziprasidone	Geodon			
Asenapine	Saphris			

Please indicate any other medication (s) you may have tried in the past to treat your psychiatric condition:

BRANDYWINE VALLEY TMS
JACK CASTRO MD

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over 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's 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

BRANDYWINE VALLEY TMS
JACK CASTRO MD

2300 Pennsylvania Ave., Ste 4C-1
Wilmington, DE 19806
P 302-635-1710 | Fax 570-221-6246

CLIENT CONSENT TO RELEASE INFORMATION

Client Name _____ DOB _____
SSN _____/_____/_____

I hereby authorize the below health care or pharmacy providers to use or disclose, in verbal and/or written form, the specific information requested below, to Brandywine Valley TMS for the purpose of receiving TMS therapy and to obtain prior-authorization for TMS treatment services.

Doctor Name	Telephone	Fax
Doctor Name	Telephone	Fax
Pharmacy Name	Telephone	Fax
Pharmacy Name	Telephone	Fax
Hospital Name	Telephone	Fax
Therapist	Telephone	Fax
Other	Telephone	Fax

One-Way Release: _____ Two-Way Release: _____

We have checked the minimum records needed to obtain a prior authorization for TMS therapy. Please check any other applicable mental health records you authorize us to request.

__X__ Treatment Summary
_____ Psychological Testing
_____ Psychological Evaluation
__X__ Psychiatric History
_____ Substance Use/Abuse History
_____ School Testing/Evaluations
_____ Medical Information History
__X__ Current/Previous Medications
_____ Hospital Admit Summary
_____ Hospital Discharge Summary

____ School Functioning/Educational _____ Other: _____

The information is being requested for the following purpose(s): Approval of TMS therapy (Transcranial Magnetic Stimulation)

This authorization shall remain in effect for 90-days from the date of the request.

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 Brandywine Valley TMS
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA
- I may refuse to sign this authorization
- I hereby release Brandywine Valley TMS 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 information

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Name: _____ Date: _____

The witness can attest to the identity of the person(s) signing above, per secure, written, identifying information.

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.

Potential Benefit to You:

Based on your clinical assessment at Brandywine Valley TMS, it has been recommended that you receive Transcranial Magnetic Stimulation (TMS), as it appears that your condition may potentially benefit from this procedure. This is based on our clinical experience with TMS, as well as evidence from research.

Description of Alternative Treatments That Might Prove Equally Advantageous:

You have been informed that there are other approved, conventional treatments for your condition, including medications, psychotherapy, electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), and ketamine. These alternative treatments have their own benefits and risks. You understand that the question of whether TMS is most appropriate for you depends on your prior experiences with these treatments, the nature of your psychiatric condition, and other considerations. The alternative to receiving TMS would be to receive conventional treatment (medications, psychotherapy, and/or ECT or VNS), or no treatment at all.

Description of Procedures:

TMS is given using a magnetic stimulator. A magnetic stimulator is a device that generates a magnetic field. The magnetic field is produced by passing an electric current through an insulated coil of wire that is held on the scalp. The coil is insulated so that the electricity stays completely inside the coil. Electricity does not directly pass through the coil onto the scalp. The magnetic field generated by the coil passes through the skull into the brain. By rapidly turning the magnetic field on and off, a small amount of electricity is briefly delivered to the brain.

TMS involves a series of treatment sessions, typically given 5 times a week. Each session lasts for about 30 minutes to 1 hour, although some protocols can be as short 3-5 min (specifically Theta Burst, or iTBS). The exact number of sessions will be determined by your doctor based upon your response. The TMS sessions will be performed in a specially equipped room. Before beginning the TMS procedures, you will be asked to remove any metal or magnetized objects (such as phone, keys, jewelry, and credit cards). TMS produces a loud clicking sound, so you will be required to wear ear plugs during the entire TMS session. Trained staff will be with you at all times. If undesirable side effects develop, you may stop the procedure at any time.

To determine the intensity of the magnetic stimulation needed in your particular case, you will undergo a test called a motor threshold (MT). The MT examines the excitability of areas of the brain by testing the response of your fingers to TMS. “Excitability” refers to the TMS’ strength level to elicit a twitching response of your fingers. These procedures require that you sit still in a chair for about 10 minutes. Your doctor will hold the magnetic stimulator over your head while it emits stimulating magnetic pulses until this causes your finger muscle to twitch. During this procedure, you will notice a clicking noise when the magnetic pulses are produced. You will wear earplugs during the procedure to protect your hearing.

TMS is a novel and biological treatment for depression and other psychiatric disorders. After successful treatment with TMS your condition may (or may not) relapse, in which case you may benefit from maintenance TMS treatment and/or other psychiatric treatments as mentioned above.

Patient Informed Consent
TRANSCRANIAL MAGNETIC STIMULATION (TMS)

You have been made aware that your MT determination and TMS treatment plan will be prescribed by your doctor. Subsequent sessions will be administered by your doctor and/or their staff, which would include a properly trained technician.

Risks:

The most commonly reported side effect of TMS is headache or scalp discomfort. Neck pain may also occur. If a headache or neck pain occurs, they are usually easily managed with standard over-the-counter analgesics such as acetaminophen or ibuprofen. You may experience some discomfort on your head where the coil is held. This is due to the contraction of muscles and stimulation of nerves on the scalp. The clicking noise made by the stimulator may temporarily affect hearing. Ear plugs reduce such risk; therefore, you will be asked to wear earplugs during TMS. Forehead and eye twitching are also very common and stop after the session ends.

TMS may have unknown side effects. You must inform the staff and your TMS administrator of any new medications or changes to existing medication that you are taking. Failure to do so may increase your risk of side effects from TMS, including seizures. The most serious known risk of TMS is seizures. TMS can trigger seizure activity if treatment is given at a high enough intensity. There are other risk factors as well. TMS has produced seizures in some patients with epilepsy. The literature contains reports of hundreds of normal volunteers and patients with depression receiving TMS and seizures are considered a possible but unlikely side effect. Brandywine Valley TMS follows the consensual safety guidelines for the use of TMS to mitigate the risk of seizures.

The strength of the magnetic field used for stimulation will be adjusted accordingly to your response to single magnetic pulses during MT determination, as described above. Persons with epilepsy, a history of seizures during childhood (“febrile convulsions”), and a family history of treatment-resistant epilepsy may be at higher risk of convulsion with TMS. Also, if you have a history of head trauma, implanted metal objects, or neurological disorder, you may be at higher risk. You will be continuously monitored during the stimulation sessions by trained staff. If warning signs of a convulsion appear, the stimulation will be stopped immediately. In spite of all these precautions, there is still a slight chance that you will experience a convulsion or other medical complication. If you have a seizure, you may require hospital admission and a follow-up neurological evaluation. Having had a seizure may adversely affect your medical insurability, your future employment, and your ability to drive.

The use of TMS also carries the risk of cognitive changes, as well as other unforeseen risks. “Cognitive” refers to thinking and memory. The risks of exposure to magnetic fields during pregnancy are unknown. You may be asked to take a pregnancy blood test before exposure to magnetic stimulation if you are woman of child-bearing capacity. If you are in this category, you agree to use an effective form of contraception until after the course of TMS sessions are completed.

Other possible risks lightheadedness or fainting and induction of mania or hypomania in patients with mood disorders such as bipolar disorder.

Patient Informed Consent
TRANSCRANIAL MAGNETIC STIMULATION (TMS)

Costs and Compensation:

The TMS Treatment Program at this practice may be covered by some insurance. This may change in the future depending on the policies and plans of insurance companies. You are responsible for all fees in relation to this service if insurance does not cover it for you. Brandywine Valley TMS does not provide compensation or payment for treatment or injuries related to this procedure, nor for wages lost as a result of injury. However, you are aware that participation in this procedure does not waive any of your legal rights to seek such compensation through the courts.

Rights of Participants:

The nature of this procedure and possible side effects have been clearly explained to you both in writing and verbally. Your participation in this procedure is completely voluntary. You may refuse to participate or withdraw at any time, without loss of benefits to which you are otherwise entitled. You understand that your right to privacy and confidentiality of your participation in this procedure, should you choose to participate, will be safeguarded. Your records, like other medical and clinical records, will be kept confidential to the extent permitted by law. Any information obtained during this procedure and identified with you will remain confidential to the extent permitted by law, and will otherwise only be available to staff, institutional personnel, or federal and Delaware State regulatory personnel.

Questions:

The conduct of TMS at this facility is under the direction of Jack Castro, MD. All questions you have about this procedure have been answered by Jack Castro, MD, or his staff, to the best of their ability. If you have further questions about the procedures or about your response to the procedures, you may contact Jack Castro, MD at 302-635-1710. You will be given the opportunity to discuss in confidence any questions you may have.

Statement of Consent:

The nature of this procedure and possible side effects have been clearly explained to you both in writing and verbally. You understand that your consent to this procedure is voluntary and that you can withdrawal consent at any time without prejudice. You have read the above and give your consent to receive the TMS procedure. Signing this form does not waive any of your legal rights. You have been given a copy of this consent form for you to keep.

Signature of patient _____

Printed name of patient _____ Date _____

I have discussed the proposed procedure with this patient and, in my opinion, this patient understands the benefits, risks and alternatives (including non-participation) and is capable of freely consenting to participate in these procedures.

Clinician obtaining consent _____

Printed name of clinician _____ Date _____

Patient Informed Consent
TRANSCRANIAL MAGNETIC STIMULATION (TMS)

Addendum for Patients Who are Pregnant:

I understand that I am pregnant and that the available reports and literature provide no evidence that TMS to the mother during pregnancy has detrimental effects on the fetus. However, that does not rule out the possibility that there could exist a range of unforeseen risks such as complications during pregnancy or problems with fetal development or congenital abnormalities in the baby, or other issues after birth such as feeding difficulties or irritability. I understand and accept these risks.

Signature of Patient _____ Date _____

BRANDYWINE VALLEY TMS
JACK CASTRO MD

2300 Pennsylvania Ave., Ste 4C-1
Wilmington, DE 19806
P 302-635-1710 | Fax 570-221-6246

This notice applies to Brandywine Valley TMS and its clinical associates

NOTICE

The privacy of your health information is important to us. We will maintain the privacy of your health information and will not disclose your information to others without your permission, or unless the law authorizes or requires us to do so.

The federal law HIPAA requires that we take additional steps to keep you informed about how we may use the information gathered to provide health care services to you. As part of this process, we are required to provide you with a Notice of Privacy Practices and to request that you sign a written acknowledgment that you received a copy of our Notice of Privacy Practices.

The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, or payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights regarding health information that we maintain about you, and a brief description of how you may exercise your rights.

If you have any questions about this notice, please contact us

What is Protected Health Information?
Protected Health Information is information that relates to:
(1) Your past, present or future physical or mental health or condition.
(2) The provision of health care including mental health care to you.
(3) The past, present, or future payment for the provision of health care including mental health care to you; and includes
(4) Demographic information that identifies you or that could be used to identify you.

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.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information (“Protected Health Information” or “PHI”). We must follow the privacy practices that are described in this Notice, which may be amended from time to time.

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in Section II G of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

a. **Permissible Uses and Disclosures Without Your Written Authorization** – We may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state Law.

i. **Payment**: We may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. For example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

ii. **Health Care Operations**: We may use or disclose PHI in connection with my health care operations, including quality improvement activities, training programs, accreditation, certification, licensing, or credentialing activities.

iii. **Communications**: We may use or disclose PHI to contact you regarding missed appointments or if we need to change our appointment time. We may leave messages on your answering machine unless you have directed me otherwise. When we communicate by cell phone or computer, be aware that the information is not always secure from access by third parties.

iv. **Treatment**: We may use PHI to diagnose and treat you. We may use PHI to inform you about treatment alternatives or other related topics. We may also use or disclose PHI for clinical coverage during periods of my absence.

v. **Required or Permitted by Law**: We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health of safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or others as authorized by law.

b. **Uses and Disclosures Requiring Your Written Authorization**

1. **TMS Therapy, Counseling, and Psychotherapy Notes**: Notes recorded by our clinician(s) documenting the contents of a counseling or treatment session with you ("Psychotherapy Notes" / "Counseling Notes") or during TMS therapy treatment will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. **Treatment**: We will not use or disclose PHI to other health providers without your written consent.

3. **Marketing Communications**: We will not use your health information for marketing communications without your written authorization.

4. **Other Uses and Disclosures**: Uses and disclosures other than those described in Section I A above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy**. You may request access to your medical record and billing records maintained by us to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

b. **Right to Alternative Communications**. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

c. **Right to Request Restrictions**. You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to such restriction you may request.

d. **Right to Accounting Disclosures**. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us. This right applies to disclosures for purposes other than treatment, payment, or health care operations and excludes disclosures made to you or disclosures otherwise authorized by you and is subject to other restrictions and limitations.

e. **Right to Request Amendment**. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain Circumstances.

f. **Right to Obtain Notice**. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

g. **Questions and Complaints**. If you desire further information about your privacy rights or are concerned that we have violated your privacy rights, you may contact the designated Privacy Officer at 302-635-1710. You may also file written complaints with the Director, Office for Civil Rights of the United States Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. **Effective Date**. This Notice is effective immediately.

b. **Changes to this Notice**. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office. You may also obtain any revised notice by contacting the Privacy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Brandywine Valley TMS.

Signature of Client _____ Date _____

If this acknowledgement is signed by a guardian, or personal representative of the client, please complete the following:

Personal Representative's Name: _____

Relationship to the Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledge of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency prevented obtaining the acknowledgement
_____Other (please explain)
_____

Employee Signature_____ Date _____

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD

BRANDYWINE VALLEY TMS
JACK CASTRO MD

2300 Pennsylvania Ave., Ste 4C-1
Wilmington, DE 19806
P 302-635-1710 | Fax 570-221-6246

Brandywine Valley TMS
FINANCIAL POLICY AND AUTHORIZATION (COMMERCIAL INSURANCE)

Brandywine Valley TMS will attempt to obtain a pre-authorization for TMS therapy treatment from your primary insurance carrier, when applicable. Please note, however, that pre-authorization does not guarantee coverage. In such cases, you are ultimately responsible for payment. You may also have co-pays and deductibles that must be met. Brandywine Valley TMS requires payment at the time of service. Total out-of-pocket costs are estimated prior to starting treatment based on your benefits check and the pre-authorization obtained from your insurance carrier.

- Any unpaid claims billed to insurance will be the responsibility of the patient and/or parent or responsible party (e.g., legal guardian, when applicable).
- Patients are responsible for all costs of their treatment and for any fees incurred due to billing or collections.
- If your insurance does not cover TMS, your out-of-pocket fee per session is $235.
- "Last-minute" cancellations (less than 24 hours' notice) and missed appointments are billed at $50. Insurance will not cover this fee.
- It is your responsibility to notify us of any changes in your insurance.
- You are responsible for all co-pays and deductibles. The total amount due will be divided over the number of treatment sessions and must be paid at each session.
- While we may submit claims to your insurance provider, you are responsible for any amounts not paid. If your insurance denies or delays payment for any reason, you are financially responsible for the full amount upon receipt of the bill.
- In cases where insurance is being used to cover treatment sessions, we will begin treatment only after receiving authorization from the insurance provider. However, if at any point during the course of treatment the insurance denies or ceases payment of claims for any reason, remaining treatment sessions will be suspended until the matter is resolved. Please be aware that interruptions in treatment may impact its overall efficacy.
- Any bill submitted to you by Brandywine Valley TMS is due upon receipt. Unpaid balances will be subject to a 1.5% monthly finance charge. If your account is sent to a third-party collection agency, you will be responsible for all collection costs, including any reasonable attorney fees incurred in the process.
- In cases of financial hardship or if you require a payment plan, please note that we are unable to directly finance your treatment sessions. However, we partner with CareCredit, a healthcare financing service. We encourage you to inquire about how to activate their services prior to beginning treatment, so you have a backup plan in place and can avoid any interruptions in your care.

Payment Options:

- Regardless of the selected payment method, a valid credit card must remain on file. When applicable, this card may be used to process any outstanding balances, co-pays, co-insurance amounts, deductibles, or fees related to missed or late-canceled appointments.

Credit/Debit Card Information:
Name on Card: _____
Card Number: _____
Expiration Date: _____ CVC: _____
Billing Address: _____

By signing below, I acknowledge that I have read, understood, and agreed to this Financial Policy:

Signature: _____
Printed Name: _____
Date: _____

BRANDYWINE VALLEY
TMS
JACK CASTRO MD

Hearing Protection Requirement Waiver

Name:_____ DOB: _____

I, _____, have been informed that it is recommended to wear ear plugs during TMS therapy treatment to protect my hearing. I choose to not wear hearing protection and will hold harmless, *Brandywine Valley TMS*, its employees, physicians, affiliates, and agents in the event of an adverse effect due to my decision. I understand that it is my choice to not wear hearing protection and I must sign this waiver whether I choose to wear or decline ear plugs.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date