SOUTH FLORIDA TMS

PATIENT REGISTRATION AND DEMOGRAPHIC FORM

DATE:

PATIENT NAME:

IS THIS YOUR LEGAL NAME:

SOCIAL SECURITY NUMBER:

PATIENT DATE-OF-BIRTH:

AGE:

SEX:

ADDRESS:

HOME PHONE:

CELL PHONE:

WORK PHONE:

EMAIL ADDRESS:

PHARMACY NAME:

PHARMACY TELEPHONE NUMBER:

SEND CLAIMS TO: SELF-PAY (OUT OF POCKET)

SEND PRIOR AUTHORIZATIONS TO:

PRIMARY INSURANCE:

SUBSCRIBER ID:

GROUP NUMBER:

WHO IS RESPONSIBLE FOR THE BILL:

PLEASE INDICATE IF OTHER:

WOULD YOU LIKE TO CREDIT CARD INFORMATION ON FILE?

The above information is true to the best of my knowledge. I understand that payment is due at time of service.	
_____	_____
Patient/Guardian signature	*Date*

SOUTH FLORIDA TMS

BRIEF PATIENT HISTORY FORM

HAVE YOU EVER HAD ANY OF THE FOLLOWING:
STROKE:
HEAD INJURY:
DEMENTIA:
ALZHEIMERS:
PARKINSONS:
DYSKINESIA:
INCREASED INTRACRANIAL PRESSURE:
FAMILY HISTORY OF SEUZRE:
EPILEPSY:
FEBRILE SEIZURES (SEIZURES IN CHILDHOOD RESULTING FROM HIGH FEVER):
ARTERIOVENOUS MALFORMATION (AVM) (ABRNOMAL FORMATION OF VESSELS IN THE BRAIN:
BRAIN ABSCESS:
BRAIN TUMOR:
CAVERNOMA:
ECLAMPSIA (SEIZURES IN PREGNANCY):
ENCEPHALITIS (BRAIN INFLAMATION):
MENINGITIS (BACTERIAL INFECTION IN THE MEMBRANES OF THE BRAIN OR SPINAL CORD):
MULTIPLE SCLEROSIS:
EXCESSIVE ALCHOL CONSUMPTION OR ALCOHOL WITHDRAWAL:
SEVER INSONMIA (> 48 HOURS WITHOUT SLEEP):
MIGRAINES OR SEVERE FREQUENT HEADACHES:
ANY NUMBNESS, PAIN, TINGLING, OR NERVE RELATED CONDITIONS INVOLVING THE FACE OR HEAD ON EITHER THE LEFT OR RIGHT SIDE?:
DO YOU HAVE ANY PAST CONDITIONS NOT PREVIOUSLY MENTIONED?:
MEDICAL DEVICES / OBJECTS / IMPLANTS:
ANEURYSM CLIP(S) OR COIL(S):

SOUTH FLORIDA TMS

CAROTID OR CEREBRAL STENT(S):

DEEP BRAIN STIMULATION ELECTRODE(S):

METALLIC DEVICES (I.E. COPPER,IRON STEEL,TITANIUM):

MAGNETICALLY ACTIVATED DENTAL IMPLANTS:

COCHLEAR/OTOLOGIC IMPLANTS:

CSF (HYDROCEPHALIS) SHUNT:

FERROMAGNETIC OCCULAR IMPALANTS:

PELLETS, BULLETS, FRAGMENTS:

TATTOOS WITH METALLIC INK:

PERMANENT MAKEUP:

HAIR EXTENSIONS:

CARIAC MEDICAL DEVICES / OBJECTS / IMPLANTS:

CARDIAC PACEMAKERS, ICD'S:

CADIAC STENTS, FILTERS, OR VALVES:

WEARABLE CARDIOVERTER DEFIBRILLATOR (WCD):

MAGNETICALLY PROGRAMMABLE SHUNT VALVE(S):

PSYCHIOLOGICAL MEDICAL DEVICES / OBJECTS / IMPLANTS:

VAGUS NERVE STIMULATOR:

WEARABLE INFUSION PUMPS:

IMPLANTED INSULIN PUMP:

RADIOACTIVE SEEDS:

STAPLES OR SUTURES:

VERICHIP MICROTRANSPONDER:

METALLIC DEVICES / OBJECTS / IMPLANTS:

METAL DENTAL BRACES:

SOUTH FLORIDA TMS

SINGLE TOOTH POSTS:

NON REMOVABLE BRIDGEWORK:

CONDUCTIVE MAXILLOFACIAL RECONSTRUCTION HARDWARE (E.G. SCREWS, PINS):

METALLIC DEVICES / OBJECTS / IMPLANTS:

EEG ELECTROD(S):

TITANIUM SKULL PLATES CERVICAL FIXATION DEVICE/CERVICAL PLATE:

REMOVABLE DEVICE / OBJECTS / IMPLANTS:

JEWELRY:

EYEGLASSES:

HEARING AIDS:

WEARBLE PHYSIOLOGIC MONITER (E.G. HOLTER):

BONE GROWTH STIMULATOR:

PORTABLE GLOCOSE MONITORS:

REMOVABLE DENTURES / BRIDGEWORK:

VAGAL NERVE STIMULATION:

ECT THERAPY:

CURRENT MEDICATIONS:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS: OVER THE COUNTER, PRESCRIPTION, HERBAL SUPPLEMENTS, VITAMINS, DAILY OR AS NEEDED:

MD SIGNATURE:_____ DATE:_____

SOUTH FLORIDA TMS

EMERGENCY CONTACT FORM

You authorize the following people to be contacted in case of emergency, or in the event you cannot be reached. You are authorizing detailed information to be given to the following:

NAME:

RELATIONSHIP:

PHONE:

NAME:

RELATIONSHIP:

PHONE:

Primary Care Doctor:

Name:

City:

Office Number:

Fax:

Psychiatrist:

Name:

City:

Office Number:

Fax:

Psychologist/Therapist:

Name:

City:

Office Number:

Fax:

Pharmacy:

Name:

City:

Telephone Number:

Fax:

Patient Signature:_____ **Date:**_____

SOUTH FLORIDA TMS
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.

If you have any questions about this Notice please contact
our Privacy Officer who is Jessica Sanchez.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health

care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the

governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and

imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health

information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or

proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction in writing only.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made

to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Jessica Sanchez .

PATIENT PRINTED NAME:

PATIENT SIGNATURE:

DATE:

SOUTH FLORIDA TMS

ELECTRONIC COMMUNICATION CONSENT FORM

Electronic Communication Consent

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are non-emergent, non-urgent or non-critical.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at this practice by electronically communicating with staff members

General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo, and Gmail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice, however, the recipients email addresses will be hidden

Healthcare team Responsibilities

- Your provider may route your email messages to other members of the staff for informations purposes or for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return email to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare team.

I acknowledge that commonly used email service are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

SOUTH FLORIDA TMS

I have been given the opportunity to discuss electronic communication with a representative.

In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I hereby consent to electronic communication via non-secure email services.
I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the address above, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent.
I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network.
I Further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent

Patient Authorized Email Address (please print):
Patient Authorized Phone Number (for text messages):
Patient Name (please print):
Patient Signature: Date:

South Florida TMS

INFORMED CONSENT FOR NEUROSTAR TMS THERAPY

This is a patient consent for the medical procedure called NeuroStar TMS Therapy®. This consent form outlines the treatment that your doctor has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you, and any alternative treatments that are available for you if you decide not to be treated with NeuroStar TMS Therapy.

The information contained within this consent form is also described in the Depression Patient's Manual for Transcranial Magnetic Stimulation with the NeuroStar TMS Therapy System which is available from your doctor. Not all information in the Manual is stated here, so you should read the Patient Manual and discuss any questions you have with your doctor. Once you have reviewed the manual and this consent form, be sure to ask your doctor any questions that you may have about NeuroStar TMS Therapy.

Dr. Gil Lichtshein has explained the following information to me:

a. TMS stand for "Transcranial Magnetic Stimulation," NeuroStar TMS Therapy is a medical procedure. A TMS treatment session is conducted using a device called the NeuroStar TMS Therapy System, which provides electrical energy to a "treatment coil" or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in Magnetic Resonance Imagining (MRI).

b. NeuroStar TMS Therapy is a safe and effective treatment for patients with depression who have not benefited from antidepressant medications.

c. Specifically, NeuroStar TMS Therapy has been shown to relieve depression symptoms in adult patients who have been treated with one antidepressant medication given at a high enough dose and for a long enough period of time but did not get better.

d. The safety and efficacy of NeuroStar TMS Therapy has not been established in patients taking two or more antidepressant medications at a high enough dose and for long enough a period of time or who did not take any antidepressants during this current period of depression.

e. During TMS treatment sessions, the doctor or member of their staff will place the magnetic coil gently against my scalp on the left front region of my head. The magnetic

fields that are produced by the magnetic coil are pointed at the region of the brain that scientists think may be responsible for causing depression.

f. To administer the treatment, the doctor or member of their staff will first position my head in the head support system. Next, the magnetic coil will be placed on the left side of my head, and I will hear a clicking sound and feel a tapping sensation against my scalp. The doctor will then adjust the NeuroStar TMS Therapy system so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right hand twitches. The amount of energy required to make my hand twitch is called the "Motor Threshold." Everyone has a different Motor Threshold and the treatments are given at an energy level just above my individual motor threshold. How often my Motor Threshold will be re-evaluated will be determined by the doctor.

g. Once Motor Threshold is determined, the magnetic coil will be moved, and I will receive treatment as a series of pulses that last about 4 seconds with a rest period of about 26 seconds between each series. Treatment is to the left front side of my head and will take about 40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. I will likely receive the treatment 5 times a week for 4 to 6 weeks (20-30 treatments). A taper TMS treatment may be prescribed by the doctors after that time. I will be evaluated periodically by the doctors during the treatment course. The treatment is designed to relieve my current symptoms of depression.

** Dr. Gil Lichtshein has explained to me that he will be using off label TMS treatment to treat my condition; and /or that TMS therapy has not been approved by the FDA for use in treating my condition. He has explained the parameters of what this off label treatment will consist of. I have agreed to this off label treatment._____(initial).

h. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one third of the patients who participated in the research studies. I understand that I should inform the doctor or his/her staff if this occurs. The doctor may then adjust the dose or make changes to where the coil is placed in order to help make the procedure more comfortable for me. I also understand that headaches were reported in half of the patients who participated in the clinical trial for the NeuroStar device. I understand that both discomfort and headaches got better over time in the research

studies and that I may take common over the counter pain medications such as acetaminophen, if headache occurs.

i. The following risks are also involved with this treatment:

The NeuroStar Therapy System should not be used by anyone who has magnetic sensitive metal in their head or within 12 inches of the NeuroStar magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. Objects that may have this kind of metal include:

- Aneurysm clips or coils
- Stents
- Implanted Stimulators
- Electrodes to monitor brain activity
- Ferromagnetic implants in your ears or eyes
- Bullet Fragments
- Other metal devices or objects implanted in the head
- Facial tattoos with metal ink or permanent makeup

j. The NeuroStar System should be used with caution in patients who have pacemakers or implantable cardioverter defibrillators (ICD's) or are using wearable cardioverter defibrillators (WCD's). Failure to follow this restriction could result in serious injury or death.

k. NeuroStar TMS Therapy is not effective for all patients with depression. Any signs or symptoms of worsening depression should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.

l. Seizures (sometimes called convulsions or fits) have been reported with the use of TMS devices. However, no seizures were observed with use of the NeuroStar TMS Therapy system in over 10,000 patient treatment sessions in trials conducted prior to the FDA clearance of NeuroStar TMS System. Since the introduction of NeuroStar TMS System into clinical practice, seizures have been rarely reported. The estimated risk of seizure under ordinary clinical use is approximately 1 in 30,000 treatments or 1 in 1000 patients.

m. Because NeuroStar TMS Therapy system produces a loud click with each magnetic pulse, I understand that I must wear earplugs or similar hearing protection devices with the rating of 30dB or higher of noise reduction during treatment.

n. I understand that most patients who benefit from NeuroStar TMS Therapy experience results by the fourth week of treatment. Some patients experience results in less time while others may take longer.

o. I understand I may discontinue treatment at any time

** Dr. Gil Lichtshein has explained to me that TMS treatment is contraindicated in my situation and has explained the risks associated with that contraindication. I have agreed to have TMS treatments despite this information._____(initial).

By signing, I agree to have read the Neurostar consent form and agree to Neurostar treatment under the treatment of Dr. Gil Lichtshein, M.D.

Patient Signature:_____ Date:_____

Patient Name:_____ Date:_____

Witness Signature:_____ Date:_____

Witness Name:_____ Date:_____

Office Use Only.

South Florida TMS

TREATMENT INFO FORM

PATIENT NAME: _____
CONTACT TELEPHONE: _____
TREATMENT START DATE: _____

PRICE PER SESSION:

TREATMENT LOG

Date	Left/ Right/ Protocol	Therapist	Scores Done?
1.			
2.			
3.			
4.			
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6.			
7.			
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9.			
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36.			

NEURONETICS

Motor Threshold Determination Worksheet

Patient ID_____

Starting SOA _____

Starting Coil Angle _____

SMT_____

					Start AP						
Cm											
Rating											

SOA										
Mark thumb twitch*										

*Consider coil rotation if can't isolate thumb response

Final AP_____ SOA_____ Coil Angle _____ SMT _____