RDT Advanced Wellness Center

RDT Group
440 West Street, Suite 318
Fort Lee, NJ 07024
Phone: 201-500-9728 | Fax: 888-512-2123

Dear Client:

Thank you for choosing RDT Group to be your TMS therapy provider. When you choose our service, you become part of a vibrant and supportive team of professionals that exists for the sole purpose of preparing you for a life of joy. You will never be "just another patient" – from the moment you walk through our door until long after you have completed the treatment phase.

Unfortunately, **most insurance networks require a prior authorization** before you begin therapy. So, to help protect each of our patients, **we ensure appropriate authorization** from your insurance is obtained before you begin treatment.

We have designed our **TMS Registration Form based on the information that will be required on your insurance's prior authorization form.** So, while we understand no one enjoys filling out these types of forms, **we ask that you please be as thorough as possible. If you cannot remember specific dates, especially where previous medications are concerned, then just list an approximate date, including month and year.**

Most insurances will require the following:

- 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 and look forward to helping you to achieve long-term relief from your depression.

Client TMS Registration Form: (Adult)

Date: _____

BASIC INFORMATION:

Patient's Full Name: _____ Date of Birth: _____ Gender: _____ Patient's SSN: _____ *Used for Insurance Reasons*

Mailing Street & Apt #: _____ *I understand that by giving this address, statements and necessary forms will 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 Research Diagnosis Therapy Group 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: _____ Optional: Do not leave voice mails on the following phone number(s): _____

Email Address: _____ Please use my email address for: ☐ TMS Clinic Communication ☐ For Clinic Updates and Newsletters

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: _____

Client TMS Registration Form: (Adult)

RDT Group
Direct: 201-500-9728
Email: rdtgroupnj@gmail.com

Financial Responsibility

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:

RDT Group 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 201-500-9728

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. If it is not provided or different from what is communicated to us by your insurance provider, 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 reflects services, you may still be responsible for payment of services provided. We make every effort to obtain re-authorization for services prior to treatment and it is your responsibility to notify our offices of any changes.

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: _____

Client TMS Registration Form: (Adult)

Financial Responsibility
Past Due Balances
Consent to Treat
Acknowledgement of HIPAA

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 two will be charged a $50.00 cancellation fee regardless of notification. 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, Research Diagnosis Therapy Group or any of its affiliates are 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 to being submitted for collections. 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 there are some instances that TMS therapy in certain circumstances, may not provide symptom relief even it I attend every session, and participation does not guarantee that my symptoms or concerns will be resolved.

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 to them. I have asked any questions I am concerned with and understand the policies outlined above.

Patient Printed Name: _____ Date: _____ Patient

Signature: _____

Client TMS Registration Form: (Adult)

Insurance Information
Referred Entity
Medications

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 your current medications *(all current psychiatric medications – please answer to the best of your knowledge as information is required to obtain pre-authorization):*

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: _____

Client TMS Registration Form: (Adult)

Pre-Authorization Criteria Acknowledgement

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.
- 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 a medical record documentation of all of the above, including other qualifying information, in order to obtain prior authorization for TMS therapy services. Research Diagnosis Therapy Group 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 RDT Group 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 have been no reported history 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 RDT Group 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 to where or decline to wear earplugs (i.e. hard of hearing, hearing loss, or any other hearing-related program.)

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: _____

Client TMS Registration Form: (Adult)

TMS Prior Authorization Information

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

Onset of symptoms: ☐ loss of hope; ☐ low self-esteem; ☐ insomnia; ☐ appetite changes; ☐ sadness; ☐ loss of interest; ☐ decreased motivation; ☐ irritability; ☐ feeling down; ☐ anxiousness; ☐ sleeping too much; ☐ lack of social activity

Current symptoms: ☐ increase in sadness; ☐ sleeping too much; ☐ increased irritability; ☐ missed work; ☐ over-eating; ☐ increased loss of appetite; ☐ crying spells; ☐ no motivation; ☐ social isolation

Do you have current thoughts of: ☐ self-harm; ☐ suicide; ☐ thoughts to harm someone else Have you participated in

outpatient therapy? ☐ Yes ☐ No; Where: _____ When (mo/yr): _____ How

long: _____ How often (weekly, monthly): _____ Do you have a therapist or counselor? ☐ Yes ☐

No; Is so, who: _____ How often do you see your therapist? _____ Type of

therapy: ☐ Group; ☐ CBT; ☐ Individual Has therapy helped to resolve depression symptoms: ☐ Yes ☐ No

Have you been hospitalized for depression in the past? ☐ Yes ☐ No; Hospital: _____ If so, what was the approximate date (mo/yr): _____

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 or doctor: _____ City: _____ When did you start TMS (mo/yr)? _____ When did you stop TMS (mo/yr): _____ Did you have greater than 50% improvement in your symptoms? ☐ Yes ☐ No

What types of therapy have you tried in the past or are currently trying? ☐ NA Please check all previous types of psychotherapy:

☐ Therapist/Counselor; ☐ Cognitive Behavioral Therapy (CBT); ☐ Client Centered Therapy (CCT/PCT); ☐ Existential Therapy; ☐ Psychoanalytic or Psychodynamic Therapy (exploration of unconscious thoughts); ☐ Dialectical Behavior Therapy (DBT); ☐ Interpersonal Psychotherapy (IPT); ☐ Mindfulness Therapy; ☐ Group Therapy; ☐ Other Therapy: _____; ☐ Extended visits with psychiatrist

At what age were you initially diagnosed with depression (estimate): Age _____ 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 RDT Group 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: _____