Srisai Gowda MD FAPA
Board Certified in General Psychiatry and Psychosomatic Medicine

Trans Cranial Magnetic Stimulation (TMS)

2106 New Road #D-8, Linwood, NJ 08221
ShoreClinicalTMS.com | 609-927-1030 | Fax: 609-927-9985

Patient Information

Name: ______________________________ DOB: ____________
Age:________ SS#: ________________ Sex: ☐ Male ☐ Female Marital Status: _______
Street Address:______________________________ City:______________
State:______ Zip Code: _______ Home: ____________ Cell Phone: ____________
Appointment reminder preference: ☐ Cell ☐ Home EMAIL______________________
How would you like to be contacted? ☐ Phone ☐ Email ☐ Text
Emergency Contact: ______________ Phone Number: ____________Relationship: ______
Patients Employer:______________________________Work Phone: ____________
Employers Address: ________________

Primary Insurance: (*responsible for insurance/ payments*)
Primary Insurance Company Name: ____________________
Primary Address: ______________________________________
ID# ________________ Group # ____________ Phone Number: ____________
Policy Holder Name: ________________Social Security Number: ____________
Date of Birth: ______________ Relationship to Patient: ______________
Street Address: ______________________________________
City______________ State ______ Zip Code ______ Phone Number: ____________

***Secondary Insurance:*____*None*______
Secondary Insurance Company Name: ____________________
Secondary Insurance Address: ______________________________
ID#:________________ Group #:____________ Phone Number: ____________
Policy Holder Name: ________________Social Security Number: ____________

IMPORTANT: PATIENT IS RESPONSIBLE FOR 1ST VISIT AUTHORIZATION—PATIENT WILL BE RESPONSIBLE FOR VISITS UNTIL AUTHORIZATION IS OBTAINED

Information and Assignment of Benefits:

I authorize the release of any medical information necessary to process all claims. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Dr. Srisai Gowda to apply for benefits on my behalf for covered services rendered by him. I request that payment from my insurance company be made directly to Dr. Srisai Gowda. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

24 BUSINESS HOUR NOTICE is required to cancel an appointment, otherwise we reserve the right to charge a fee for the time reserved.

We will bill your insurance company as a courtesy for services rendered. I understand, ultimately I am financially responsible if the claims are not paid by the insurance in a reasonable period of time.

Signature: ______________________ Date: ____________________

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Consent to use and disclose your health information

I appreciate your business and being of service to you. My office staff and I are committed to complying with the Privacy Regulations of the Health Insurance and Accountability Act of 1996 (HIPAA). Your privacy and protection of your health information is important to us. It is a responsibility that we take seriously. As part of the HIPAA privacy regulations, I am required to provide you the "Notice of Privacy Practices" that describes our responsibility and your rights under these regulations.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for the business or government functions. By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practice explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do not change it, you get a copy by calling us at 609 927.1030.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on buy we may already have shared or used some of your information and cannot change that.

Sincerely,
Srisai Gowda, M.D.

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Signature of client/personal representative Date

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Printed name of client or personal representative Relationship to the client

Date of NPP 4/14/03 Copy gave to the patient/chart/personal representative

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Informed Consent for Treatment

I ____________________(name of patient), agree and consent to participate in behavioral health care services offered and provided by **Srisai Gowda, M. D., a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: the scope of the Psychiatrist's license, certification, and training.**

It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor before taking any medication.

Initial_______

Coordination of Treatment (Primary care/other Physician)

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or other health care providers if needed. Your consent is valid until discharge. **Please understand that you have the right to revoke this authorization, in writing at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.** If you prefer to decline consent, no information will be shared.

____you may inform my physician(s)   ___I decline to inform my physician

PHYSICIAN NAME;________________________Phone:______________

Signature:_______________________________________ Date:__________________

Relationship to Patient (if applicable)_______________________________________

Random Drug Testing for Patient on Controlled Medication

Due to a higher incidence of misuse/abuse of controlled substances, we may do random spot drug test in our office ($15 cost) for those consistently receiving CDS (Adderal, Suboxone, Xanax etc) .

Initial_______

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Health Questionnaire:

Name: ______________________

Date of Birth: ________________

Current Medications: Name, Dosage and How Often Taken: ____________________

______________________________ ____

______________________________ ____

______________________________ ____

______________________________ ____

Allergies: ____

Medical Conditions: ____

(e.g.; seizures, head injury, BP, etc)

Have you had any Psychiatric Treatment in past? Y/N: _________

When/Where? : ____

Family History: ____

(e.g.; anxiety, mental illness, alcoholism)

Social History:

Marital/Relationship Status:____

Living situation:____

(who all live in the household, # of children)

Occupation:_________________________ **Education** (highest level) **:**_______________

Reason For Today's Office Visit: ____

____

____

Recent Stressful events? ____

____

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NAME: ______________________________ **DATE:** __________

In the last week, including today, how much have you been distressed by the following:

0=Not at all 1=A little bit 2=Moderately 3=Quite a bit 4=Extremely

BSI	LINE	0	1	2	3	4	
A	1	0	1	2	3	4	Nervousness or shaking inside
G	2	0	1	2	3	4	Faintness or dizziness
I	3	0	1	2	3	4	The idea that someone can control your thoughts
H	4	0	1	2	3	4	Feeling others are to blame for most of your troubles
F	5	0	1	2	3	4	Trouble remembering things
D	6	0	1	2	3	4	Feeling easily annoyed or irritated
G	7	0	1	2	3	4	Pains in heart or chest
E	8	0	1	2	3	4	Feeling afraid in open spaces or on the street
B	9	0	1	2	3	4	Thoughts of ending your life
H	10	0	1	2	3	4	Feeling that most people cannot be trusted
J	11	0	1	2	3	4	Poor appetite
A	12	0	1	2	3	4	Suddenly scared for no reason
D	13	0	1	2	3	4	Temper outbursts that you could not control
I	14	0	1	2	3	4	Feeling lonely even when you are with people
F	15	0	1	2	3	4	Feeling blocked in getting things done
B	16	0	1	2	3	4	Feeling lonely
B	17	0	1	2	3	4	Feeling blue
B	18	0	1	2	3	4	Feeling no interest in things
A	19	0	1	2	3	4	Feeling fearful
C	20	0	1	2	3	4	Your feelings being easily hurt
C	21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
C	22	0	1	2	3	4	Feeling inferior to others
G	23	0	1	2	3	4	Nausea or upset stomach
H	24	0	1	2	3	4	Feeling that you are watched or talked about by others
J	25	0	1	2	3	4	Trouble falling asleep
F	26	0	1	2	3	4	Having to check and double-check what you do
F	27	0	1	2	3	4	Difficulty making decisions
E	28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
G	29	0	1	2	3	4	Trouble getting your breath
G	30	0	1	2	3	4	Hot or cold spells
E	31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
F	32	0	1	2	3	4	Your mind going blank
G	33	0	1	2	3	4	Numbness or tingling in parts of your body
I	34	0	1	2	3	4	The idea that you should be punished for your sins
B	35	0	1	2	3	4	Feeling hopeless about the future
F	36	0	1	2	3	4	Trouble concentrating
G	37	0	1	2	3	4	Feeling weak in parts of your body
A	38	0	1	2	3	4	Feeling tense or keyed up
J	39	0	1	2	3	4	Thoughts of death or dying
D	40	0	1	2	3	4	Having urges to beat, injure, or harm someone
D	41	0	1	2	3	4	Having urges to break or smash things
C	42	0	1	2	3	4	Feeling very self-conscious with others
E	43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
I	44	0	1	2	3	4	Never feeling close to another person
A	45	0	1	2	3	4	Spells of terror or panic
D	46	0	1	2	3	4	Getting into frequent arguments
E	47	0	1	2	3	4	Feeling nervous when you are left alone
H	48	0	1	2	3	4	Others not giving you proper credit for your achievements
A	49	0	1	2	3	4	Feeling so restless you couldn't sit still
B	50	0	1	2	3	4	Feelings of worthlessness
H	51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
J	52	0	1	2	3	4	Feelings of guilt
I	53	0	1	2	3	4	The idea that something is wrong with your mind