Vortex Psychiatry

VORTEX PSYCHIATRY & TMS CLINIC

STEP INTO THE LIGHT AND OUT OF YOUR VORTEX

Vortex Psychiatry is a forward-thinking specialty clinic that uses Transcranial Magnetic Stimulation (TMS) to provide effective, non-pharmaceutical treatment for mental health conditions. TMS is leading the field in treating patients who have depression and other mental health problems, as well as conditions affecting the nervous system.

Medical Director Said A. Ibrahimi, M.D., leads a team passionate about helping patients who are experiencing some of the most debilitating mood disorders using innovative approaches with proven benefits.

Mental health and neuropathic conditions can be challenging to treat, as patient responses to treatments can vary so dramatically. Many patients find little or no relief even after trying multiple forms of medication, but TMS gets to the root of the problem by focusing on the areas of the brain from which these conditions arise. Using state-of-the-art technology to administer painless and safe therapies. The team at Vortex Psychiatry, can precisely stimulate the right parts of the brain to restore function, improve blood flow, and reduce symptoms. You will meet highly qualified staff that excels at their roles and has a sincere desire to improve the lives of their many grateful patients. We will do everything possible to ensure your privacy, comfort, and most importantly, your safety and wellness.

TREATMENT COURSE

The FDA recommended treatment for depression is 20-36 sessions usually performed 5 days a week. It is a noninvasive outpatient procedure, usually 20-35 minutes in length, that is pre-scheduled with no restriction on activities including driving before and after the treatment. The first session, known as the Motor threshold (MT), lasts approximately 1 hour. Please expect daily appointment last at least 30-45 minutes. This includes check in and out.

____Initial here

DAY OF THE TREATMENT

- You can perform your normal daily activities before and after the treatment with no restriction to eating, drinking, or driving. (Do not consume caffeine, tobacco, cannabis, vape, or alcohol before or after treatment as there can be life threating consequences)
- If you are on daily medications make sure you keep the same schedule whether they are psychiatric or non-psychiatric medications. If you take medications as needed for anxiety or pain make sure you mention it to the technician prior to treatment, normally there is no restriction associated with that.
- You might experience some discomfort or pain especially with the initial treatment. If you have any discomfort, please mention to your Technician right away.
- During the treatment you will be awake and alert. You may not fall asleep.

Please dress comfortably and casually for your treatment. If you have longer hair, please wear it down and be sure that there are no metal accessories attached, i.e., bobby pins or clips. ____ Initial here

4155 Blackhawk Plaza Circle
Suite 240, Danville, CA 94506
www.VortexPsychiatry.com
Office: (925) 648-2650 Office: (925) 648-2651
Fax: (925-648-2530)

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PATIENT INFORMATION

Date: __________________

How did you hear about us? _____________________

Name: ______________________________ Age: ______________ Date of Birth: __________

Best contact phone number: ________________________ Email: ____________________________

Address: _____________________________City: ______________State: _________ Zip: ________

Marital Status: _______________ Gender: ____________

Employer's Name: ____________________________________ Phone: __________________

Address: ____

Occupation: ____

Emergency Contact Name: _______________________ Best Contact Phone: _____________

Relationship to Patient: _______________

INSURANCE INFORMATION:

Guarantor Name: _____________________________________Date of Birth: _______________

Primary Insurance: ____________________________________ Phone: ____________________

ID#: _________________________________ Policy, Group or Local #: _____________________

If applicable, I authorize release of medical information, necessary to process my claims and payment of medical benefits to this provider for services rendered. I understand that I am responsible for all charges incurred at the time of service. My signature authorizes Vortex Psychiatry to charge services rendered as needed to the credit card on file. I have read and agree to the Conditions of Service, Financial Policy and Consent for Treatment.

Signature of Insured or Authorized Person: _____________________________________Date: ___________

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CONDITIONS OF SERVICE

We value and respect your time as we reserve the appointment for you. Should you need to cancel or change your scheduled appointment time, please give our staff 24-hour notice so that we can make the proper adjustments to the schedule. We will do our best to accommodate rescheduling with short notice. Vortex Psychiatry methods of contact:

Website: www.vortexpsychiatry.com
Email address: vortexpsychiatry@outlook.com
Office (925) 648-2650 Office (925) 648-2651

When starting TMS treatment, we ask you do not plan to take any time off during treatments, which includes extended periods of time, as this can interfere with receiving the full benefit from TMS therapy. Time off TMS therapy can be scheduled before starting treatment.

I UNDERSTAND ALL APPOINTMENT TIMES HAVE BEEN RESERVED FOR ME AND/OR MY FAMILY.
MY CANCELLATION OF THIS TIME REQUIRES **24 Hour** NOTICE via email or by phone.

No show, late notice, same-day cancellation up to $190.00 FEE **Initials:__________**

IT IS ADVISABLE FOR ME TO **ARRIVE ATLEAST 5 MINUTES PRIOR TO MY APPOINTMENT** **Initials:_________**

Confidentiality:_____

Certain circumstances are exceptions to the laws of confidentiality, under which a physician/therapist is legally required to report. These include:

- Intent to harm yourself (suicide)
- Intent to harm another person(s)
- Child, physical and/or sexual abuse
- Abuse of an elder or dependent adult

Initials:__________

Financial Policy

Initials:__________ **Full payment of coinsurance/deductible/ and/or co-pay with your insurance, are expected each visit and is required at the time of service. If you receive insurance reimbursement for services provided by Vortex Psychiatry, you are to notify the office as soon as possible so payment can be made for services that were rendered to you. Private pay patients cannot submit to insurance for reimbursement due to agreement of private pay fee schedule. Non-approved FDA (off label) treatments cannot submit for insurance reimbursement. We accept MasterCard, Visa, Discover, and American Express. Should fees for rendered services not be satisfied with**

Family Member(s)/Parent(s)/Guardians of Disabled Adult Patients: **Initials:__________**

Family member(s)/parent(s)/guardian of disabled patients, who are chronically ill adults, are required to complete all financial documents and accept full financial responsibility for the treatment of their disabled adult relative. Disabled adult patients need to sign an Exchange of Information form. This allows the staff to discuss the financial and clinical information with the family member(s)/parent(s)/guardian of the disabled adult. The professional staff will discuss the patient's treatment, if an Exchange of Information form is signed by the disabled adult patient. Conservatorship document copies will be accepted in lieu of an Exchange of Information form.

I have read and understand these statements and agree to abide by these policies.

Patient's Signature: ___________________________________ Date: ___________________

Parent/Guardian's Signature: __________________________Date: ____________ Relationship to Patient: ___________________

Vortex Psychiatry

CONSENT FOR TREATMENT

I intend that this provider of health services will provide:

Patient's Name: ____________________
Patient's Date of Birth: _______________

I consent to behavioral health and consultation services including Transcranial Magnetic Stimulation, and other treatment modalities as appropriate.
I understand that once I submit my completed packet to the office, they will contact me. I understand I will have one TMS evaluation and screening with the Provider. The insurance will be informed that TMS treatments and any pre-authorization, evaluation, and screening for TMS (forms). Any documents will be sent to the insurance company for prior authorization of the TMS treatments. Private pay patients will be directed to a private pay fee schedule. At the business office's direction, the second appointment is established to determine patient's Motor Threshold (treatment plan) followed by the first TMS treatment.

Please plan for the first appointment to be minimum one hour. Subsequent daily appointments will be approximately 27-30 minutes daily. Every 10th treatment, or as directed by Medical Director, you will complete several depression rating scales and a check in with treating Psychiatrist.

I further understand that certain circumstances are exceptions to the laws of confidentiality, under which a provider is legally required to report. These include:

- Intent to harm yourself (suicide)
- Intent to harm another person(s)
- Child abuse, physical and/or sexual
- Abuse of an elder or dependent adult

If the Provider reasonably believes one of these exceptions applies, they will make every effort to resolve the issue by discussing it with you.

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Date: ___________________

Signature: ____
Relationship to Patient: ___________________________________
Parent/Guardian's Signature: ______________________________
Relationship to Patient: ___________________________________

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LIST ALL PRIOR ATTEMPTS TO CORRECT PROBLEM/PRIOR PSYCHIATRIC HISTORY

PLEASE LIST THE FOLLOWING:

Provider Name Address/Phone of Provider	Type of Treatment	Duration and Outcome	Currently attending Y/N	Reason for Discontinuation

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LIST ALL CURRENT AND PAST MEDICATIONS

Example of side effects:

Abnormal digestion * Acne * Agitation * Akathisia * Brain Fog * Constipation * Cough * Decreased libido * Diarrhea * Dizziness * Drowsiness * Dry Mouth * Fatigue Feeling hot or cold * Gas * Hand tremor * Headache * Impotence * Increased sweating * Ineffective * Insomnia * Involuntary motion of the head, neck, arms, body, or eye * Joint/Muscle pain* Lightheadedness * Mental Slowness * Nausea * No appetite * Rapid heart rate * Skin Rash * Sleep disturbance * Slurred speech Sore throat * Stomach pain * Strange dreams * Stuffy nose * Tightness in the chest * Tremors * Trouble breathing * Trouble sleeping * Upset stomach * Weight gain

Medication	Dosage	Side effects	Indicate the reason for Discontinuation or if currently taking

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Do you have a history of Thyroid problems? No _____ Yes _____ If yes, please explain:

____

Describe any history of head trauma or being knocked out.

____

____

Have you ever had any seizures or seizure-like activity? (If so, please describe)

____

____

Have you ever had any periods of spaciness or confusion? (If so, please describe)

____

____

Do you have any prior medical hospitalizations? (If so, please give the date or age, cause, and outcome)

____

____

CURRENT LIFE STRESSORS: Include anything that is currently stressful.
examples include relationships, job, school, finances, and children:

____

____

Social activities: Please describe your relationships with peers & siblings while growing up, i.e., clubs, organizations.

____

____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

____

____

Educational History:

Last grade completed _________ College _____________ Trade/Vocational School _________________

Alcohol and Drug History: (Please list each recreational drug [including alcohol] separately including the age you started and stopped [if relevant] including how that substance made you feel and what benefit you got from it.) These include: alcohol, hard liquor, beer, wine; steroids, prescription tranquilizers or sleeping pills; inhalants: glue, gasoline, cleaning fluids, etc.; marijuana, hash, cocaine, crack, amphetamines, crank, ice, ecstasy; opiates: heroin, codeine, morphine, or other pain killers; barbiturates, hallucinating drugs: LSD, mescaline, mushrooms, or PCP.

____

____

Have you ever experienced withdrawal symptoms from alcohol/drugs? No ☐ Yes ☐

(Length of time and duration of withdrawal?)

____

____

Have you ever felt guilty about your drug/alcohol use? No ☐ Yes ☐

____

Have you ever or currently use(d) drugs/alcohol first thing in the morning or to sleep? No ☐ Yes ☐

____

If you are currently consuming alcohol, please indicate how often and how much, as alcohol can have a negative impact with TMS therapy.

____

Are you currently using any recreational drugs (also including but not limited to Cannabis and Vape), please indicate how much and how often?

____

Caffeine: please give your average use per day including source and estimated quantity

____

Nicotine: estimate your average use per day both past and present (nicotine is in tobacco, cigarettes, cigars, chew, pipe, and vape)

____

Describe any history of being physically, emotionally, sexually or verbally abused:

____

____

FAMILY HISTORY

Family Structure: – who lives in your current household?

Name:	Age:	Relationship to you:

Current Marital or Relationship Satisfaction:

____

Significant Developmental Events: these are those positive and negative experiences that have had a significant impact on your life (examples include, but are not limited to marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)

____

____

Describe your relationships within your family between siblings, parents, your neighbors, local and community activities

____

____

Describe yourself:

____

____

Describe your strengths:

____

____

Include any other important details about yourself that you would like us to be aware of:

____

____

Thank you for the confidence you have in us.
We welcome your questions and feedback.

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