441 Watertower Circle, Suite 200
Colchester, VT 05446
Phone: (802) 404-1492 Fax: (802) 404-1490

INTAKE FORM

The treatment and counseling work we do is unique to you, just as it is to each one of our patients. Before we get started we need to collect some general information from you.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth (MM/DD/YYYY) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email

EMERGENCY CONTACT

First Name | Last Name

Phone | Relationship

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE | **Policy Holder**

Policy Holder D.O.B. (MM/DD/YYYY) | Relationship

Policy Holder Address

City | State | Zip Code

Policy Number | **Group Number**

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

PARENT/GUARDIAN INFORMATION (If applicable)

First Name Last Name

Phone Relationship

First Name Last Name

Phone Relationship

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ **YES** ☐ **NO**

If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist or psychiatric provider (e.g. NP or PA)? ☐ **YES** ☐ **NO**

If yes, when and by whom?

Have you ever received counseling or psychotherapy in the past? ☐ **YES** ☐ **NO**

If yes, when and by whom?

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	*Dates*
ANTIDEPRESSANTS							
Amitriptyline	Elavil						
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL						
Citalopram	Celexa						
Clomipramine	Anafranil						
Desipramine	Norpramin						
Desvenlafaxine	Pristiq						
Doxepin	Sinequan, Silenor						
Duloxetine	Cymbalta						
Escitalopram	Lexapro						
Fluoxetine	Prozac, Sarafem						
Fluvoxamine	Luvox, Luvox CR						
Imipramine	Tofranil						
Isocarboxazid	Marplan						
Levomilnacipran	Fetzima						
Milnacipran	Savella						
Mirtazapine	Remeron, Remeron SolTab						
Nefazodone	Serzone						
Nortriptyline	Pamelor						
Paroxetine	Paxil, Paxil CR						
Phenelzine	Nardil						
Selegiline Transdermal	Emsam						
Sertraline	Zoloft						
Tranylcypromine	Parnate						
Trazodone	Desyrel, Oleptro						
Venlafaxine	Effexor, Effexor XR						
Vilazodone	Viibryd						
Vortioxetine	Trintellix, Brintellix						
Levomilnacipran	Fetzima						
Esketamine	Spravato						
Ketamine							
Brexanolone	Zulresso						
Dextromethorphan/bupropion	Auvelity						
ANTIPSYCHOTICS "major tranquilizers"							
Aripiprazole	Abilify						
Asenapine	Saphris						
Brexpiprazole	Rexulti						
Cariprazine	Vraylar						
Chlorpromazine	Thorazine						
Clozapine	Clozaril, FazaClo, Versacloz						
Fluphenazine	Prolixin, Prolixin Decanoate						
Haloperidol	Haldol, Haldol Decanoate						
Iloperidone	Fanapt						

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Loxapine	Loxitane						
Lurasidone	Latuda						
Molindone	Moban						
Olanzapine	Zyprexa, Zyprexa Zydis, Zyprexa, Relprevv						
Paliperidone	Invega, Invega Sustenna, Inrega Trinza						
Perphenazine	Trilafon						
Pimavanserin	Nuplazid						
Quetiapine	Seroquel, Seroquel XR						
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab						
Thioridazine	Mellaril						
Thiothixene	Navane						
Trifluoperazine	Stelazine						
Ziprasidone	Geodon						
Lumateperone	Caplyta						
Olanzapine/samidorphan	Lybalvi						
ANXIOLYTICS "anti-anxiety" "minor tranquilizers"							
Alprazolam	Xanax, Xanax XR						
Buspirone	BuSpar						
Chlordiazepoxide	Librium						
Clonazepam	Klonopin, Klonopin Wafers						
Clorazepate	Tranxene						
Diazepam	Valium						
Hydroxyzine	Vistaril, Atarax						
Lorazepam	Ativan						
Oxazepam	Serax						
Propranolol	Propranolol						
ANTICHOLINESTERASE/ALZHEIMER'S AGENTS							
Donepezil	Aricept						
Galantamine	Razadyne						
Memantine	Namenda, Namenda XR						
Rivastigmine	Exelon						
Selegiline	Eldepryl						
Tacrine	Cognex						
Aducanumab	Aduhelm						
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral						
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv						
Bupropion	Zyban						
Disulfiram	Antabuse						
Methadone	Dolophine						
Naltrexone	ReVia, Vivitrol						

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Varenicline	Chantix						
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR						
Fluoxetine/Olanzapine	Symbyax						
Gabapentin	Neurontin						
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT						
Levetiracetam	Keppra, Keppra XR						
Lithium	Eskalith, Eskalith CR, Lithobid						
Oxcarbazepine	Trileptal						
Tiagabine	Gabitril						
Topiramate	Topamax						
Valproate	Depakene, Depakote, Depakote ER, Valproic Acid						
PSYCHOSTIMULANTS							
Amphetamine Salts	Adderall, Adderall XR						
Armodafinil, Pemoline	Nuvigil, Cylert						
Atomoxetine	Strattera						
Dexmethylphenidate	Focalin, Focalin XR						
Dextroamphetamine	Dexedrine, Dextrostat						
Lisdexamfetamine	Vyvanse						
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR						
Methylphenidate Transdermal	Daytrana						
Modafinil	Provigil						
Viloxazine extended release	Qelbree						
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec						
Eszopiclone	Lunesta						
Flurazepam	Dalmane						
Ramelteon	Rozerem						
Suvorexant	Belsomra						
Temazepam	Restoril						
Triazolam	Halcion						
Zaleplon	Sonata						
Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar						
Daridorexant	Quviviq						
OTHER							
Benztropine	Cogentin						

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Clonidine	Catapres, Kapvay						
Cyproheptadine	Periactin						
Diphenhydramine	Benadryl						
Guanfacine	Tenex, Intuniv						
Prazosin	Minipress						
Propranolol	Inderal						
Trihexyphenidyl	Artane						
HERBAL PREPARATIONS							

☐ I am unable or unwilling to complete this form. ☐ I have completed this form to the best of my ability.

Signature of Patient/Parent/Guardian: **Date:**

☐ Reviewed in person with the patient.

☐ Reviewed over the phone with the parent/guardian of the patient.

☐ Reviewed in person with the patient and / or parent/guardian of the patient.

Signature of Psychiatrist/NPP: **Date/Time:**

NORTH COUNTRY BEHAVIORAL MEDICINE
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PSYCHOTHERAPY AND COUNSELING HISTORY

Have you received, or are you currently receiving, psychotherapy/counseling services? YES ☐ NO ☐

If so, please provide the name of the therapist or facility, address, date range in which you received treatment, and if possible, the type of therapy/therapies received.

Please provide as much of the requested information as possible.

The information in this section is very important as it is required for insurance authorization purposes

Name of therapist or facility: _____
Address of therapist or facility: _____
Date range of treatment: _____
Type of therapy provided: _____

Name of therapist or facility: _____
Address of therapist or facility: _____
Date range of treatment: _____
Type of therapy provided: _____

Name of therapist or facility: _____
Address of therapist or facility: _____
Date range of treatment: _____
Type of therapy provided: _____

Name of therapist or facility: _____
Address of therapist or facility: _____
Date range of treatment: _____
Type of therapy provided: _____

Name of therapist or facility: _____
Address of therapist or facility: _____
Date range of treatment: _____
Type of therapy provided: _____

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

TMS INFORMED CONSENT

Patient Name: _____ DOB: _____

Ordering NCBM Physician: _____

This is a patient informed consent for Transcranial Magnetic Stimulation Therapy (TMS). This informed consent outlines the treatment that has been prescribed, what to expect at treatment sessions, the risks and contraindications of such treatment, and what you are expected to report before and during your treatment schedule. You will be receiving TMS for the treatment of Major Depressive Disorder (MDD)

What is TMS?

Transcranial Magnetic Stimulation (TMS) is a noninvasive treatment which involves the use of a magnet to send brief magnetic pulses to the Dorsolateral Prefrontal Cortex (DLPFC). The DLPFC is the area of the brain that is said to control our thoughts, regulate our mood and emotions and subsequently cause depression. When a person stops responding to antidepressant medication and depression persists, it is with small magnetic impulses we are able to stimulate the DLPFC and awaken it; hence helping to alleviate the depression. These pulses are administered by placing a magnetic coil on your scalp adjacent to the location of the DLPFC. TMS has been cleared by the Food and Drug Administration and is recommended for the treatment of severe major depression. The device used in our office is the MagVenture MagPro. Additional information on this device and frequently asked patient questions can be found at www.magventure.com/us/patients-and-relatives.

What to expect from TMS?

At your first TMS treatment session, once you have been fitted with a cap and measurements have been taken to locate the motor strip and treatment location, one of our licensed physicians and a trained TMS technician will place a magnetic coil over your scalp. In order to calibrate the intensity of TMS that you will need, we will stimulate the region of your brain that makes your thumb move. You will hear a clicking sound and feel a light tapping sensation on your scalp. The device will be adjusted up or down to give only enough energy to send pulses that will cause your thumb and/or fingers to twitch. The amount of stimulation it takes to lightly cause your thumb and/or fingers to move is called a motor threshold (MT). Once your MT is determined, the magnetic coil will be moved to the predetermined area of the scalp just over the DLPFC; this is the area of the brain which we will be stimulating. You will then be given your first treatment. Ear plugs are available and recommended per your request. We will begin treatment at 80% of your determined MT. Each subsequent treatment will increase by 10% until we have reached a maximum amount of 120% of your determined MT. Treatments will be given by the technician alone, but a clinically licensed professional is always immediately available in the case of an emergency or other urgent matters. Within 2-3 weeks of beginning treatment you can expect to have your MT measured again so that we may make any necessary adjustments. TMS consists of 36 treatment sessions to be given over a period of 9 weeks. Consistency is the key in obtaining the best possible chance of improvement from depression and hopefully remission. Failing to be consistent with scheduled sessions can and will likely reduce your likelihood for success. In addition to keeping your scheduled sessions, you will be asked to fill out TMS score sheets on a weekly basis. These are the BDI-II, the PHQ-9 and the WHO-5 sheets which you filled out prior to your TMS evaluation. These score sheets are useful in monitoring your progress and will help us determine if further treatment would be beneficial. Please keep in mind that TMS is not an effective treatment for all patients. Most patients who benefit from TMS experience results by the sixth week of treatment. Some patients may experience results in less time, while others may take longer. Understand that you may discontinue your treatment of TMS at any time.

NORTH COUNTRY BEHAVIORAL MEDICINE
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Potential Risks and Contraindications

Any symptoms or behaviors suggesting a worsening depression or any signs of suicidal thoughts or behaviors should be reported immediately. Any other noticeable or questionable symptoms should be discussed with your doctor or TMS technician. We recommend a family member, caregiver or someone you trust work with you to help you monitor your symptoms and/or improvement thereof. Some common side effects include headache and/or a bruising sensation at the site of treatment. These are both usually mild and should subside within 1-2 weeks of beginning treatment. Although low, there is a risk of seizure in a small percentage of patients. It is very important that you fill out the safety checklist fully and completely so that your evaluating physician can assess any potential risks personal to your case. TMS may not be administered to patients who have magnetic sensitive metal in their head or within 12 inches/30cm of the TMS treatment coil; unless it can be removed. Failure to follow this restriction could result in serious injury or death. Objects that may have this kind of metal include but are not necessarily limited to:

- Aneurysm clips, coils, stents or sutures
- Carotid/heart or cerebral stents or clips
- Insulin pump
- Defibrillator or Pacemaker
- Implanted stimulators (deep brain, vagus nerve, bone growth or other)
- Electrodes to monitor your brain activity
- Ferromagnetic implants in your ears or eyes (for ex: Cochlear implants)
- Bullet, pellet, shrapnel fragments or any other magnetic material
- Magnetically activated dental implants
- Facial tattoos or permanent makeup which contains metallic ink
- Other metal devices or objects implanted in the head in or around your head, face, neck, or chest.

Please be sure to discuss with your evaluating physician **ANY** and **ALL** foreign material that may be implanted anywhere within your body, as well as **ANY** seizure history to be sure to eliminate any potential risk.

In Conclusion:

I have read the information contained in this informed consent form regarding what TMS is, what to expect during treatment, as well as the risks and possible contraindications associated with TMS. By signing below, I am acknowledging that I understand this information, and all of my questions have been answered to my satisfaction. I have reviewed the list of potential contraindications and have advised the technician and/or evaluation physician any which might apply. In acknowledgement of this information, I wish to go forward with the TMS treatment which has been prescribed for me.

_____ _____
Printed Name of Patient DOB

_____ _____
Patient Signature Date

_____
Printed Name and Title of Witnessing Clinical Staff

_____ _____
Witnessing Staff Signature Date

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

CONSENT TO TREATMENT

First Name: Last Name:

You are about to take a very important step in your mental health treatment, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____**(Initial)**

You are our patient and have confidentially rights. Confidentiality does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, patients that have not been seen in 6 months may be considered inactive. A new evaluation will be required for any inactive patient to be seen.

_____**(Initial)**

I, _____(patient), do hereby seek and consent to take part in the treatment provided by North Country Behavioral Medicine PLLC. If I am attending group services I also understand and consent that confidentiality still applies and that North Country Behavioral Medicine PLLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____**(Initial)**

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
_____**(Initial)**

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, North Country Behavioral Medicine is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone: Email:

_____ **(Initial)**

_____	_____	_____
Patient Name (please print)	Patient Signature	Date

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

LIFETIME INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

First Name: Last Name:

Release of Information: I, the subscriber named below, authorize North Country Behavioral Medicine PLLC and any providers working under North Country Behavioral Medicine PLLC examining or treating me to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and or diagnosis.

Physician Insurance Assignment: I, the below named subscriber, herby authorize payment directly to North Country Behavioral Medicine PLLC for my treatment at this office that is otherwise payable to me for their services as described.

Medicare/Medicaid – Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

This assignment will remain in effect until revoked by me writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 90 days.

Patient Name (please print)

Patient/Guardian Signature Date

Insurance Company

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

HIPPA NOTICE/PRIVACY PRACTICES

First Name: Last Name:

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.

North Country Behavioral Medicine PLLC, 441 Watertower Circle, Suite 200, Colchester, VT 05446
(802) 404-1492

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our office.

See front office for "HIPPA Detail" forms.

Patient Name (please print)

Patient/Guardian Signature Date

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

_____ DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ STAFF PERSON'S NAME AND TITLE

_____ SIGNATURE

_____ DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

TMS SPECIFIC CANCELLATION AGREEMENT

In order to better serve our TMS patients, we have instituted a cancellation policy. We require notice of all TMS cancellations by the close of business on the day before a patient's appointment. If an appointment is missed, cancelled or rescheduled without prior-day notice, a **$50** charge will be billed to the patient. If this appointment is for an initial motor determination or subsequent motor determination, this fee will be **$100**.

By signing below I am acknowledging that I have been advised of the cancellation policy.

While we do remind you of your appointment, it is your responsibility to call the office at (518) 825-1555, to cancel.

Patient Name (please print) _____

Patient Signature _____ Date _____

I understand that the office of North Country Behavioral Medicine PLLC will attempt to bill my insurance for services rendered, however ***if my insurance does not pay, for whatever reason, I am responsible for any remaining balance*.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- I will adhere to the guidelines above to the best of my ability.

Patient Name (please print) _____

Patient Signature _____ Date _____

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

STATEMENT OF NON-DISCRIMINATION

This Practice does not differentiate or discriminate in the treatment of Persons on the basis of, to include, but not limited to: veteran status, race, ethnicity, mental or physical disability or medical condition, sexual orientation, gender, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, color, sex, age, religion, national origin, place of residence, health history, health status, handicap, source of payment or status as a Person.

Signature	Printed Name	Date

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

SAFETY REVIEW FOR TMS

To assess if TMS is a safe treatment for you, we need you to answer the following questions:

1. Do you have epilepsy or have you ever had a convulsion or a seizure? Yes ☐ No ☐

2. Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s)? Yes ☐ No ☐

3. Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness? Yes ☐ No ☐

4. Do you have any hearing problems or ringing in your ears? Yes ☐ No ☐

5. Do you have cochlear implants? Yes ☐ No ☐

6. Are you pregnant or is there any chance that you might be? Yes ☐ No ☐

7. Do you have metal in the brain, skull or elsewhere in your body (e.g., splinters, fragments, clips, etc.)? If so, specify the type of metal. Yes ☐ No ☐

8. Do you have an implanted neurostimulator (e.g., DBS, epidural/subdural, VNS)? Yes ☐ No ☐

9. Do you have a cardiac pacemaker or intracardiac lines? Yes ☐ No ☐

10. Do you have a medication infusion device? Yes ☐ No ☐

11. Are you taking any medications? If yes please list here: Yes ☐ No ☐

_____
_____
_____
_____
_____

12. Did you ever undergo TMS in the past? If so, were there any problems? Yes ☐ No ☐

13. Did you ever undergo MRI in the past? If so, were there any problems? Yes ☐ No ☐

Printed Name: _____ Signature: _____ Date: _____

BDI®-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

25 26 27 28 29 30 A B C D E 281283-1 321

Product Number 0154018392

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

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

Psychiatric Research Unit
WHO Collaborating Centre in Mental Health

WHO (Five) Well-Being Index (1998 version)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

	Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	**I have felt cheerful and in good spirits**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	**I have felt calm and relaxed**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	**I have felt active and vigorous**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	**I woke up feeling fresh and rested**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	**My daily life has been filled with things that interest me**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Scoring:

The raw score is calculated by totalling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life.

To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.

PSYCHOTHERAPY AND COUNSELING HISTORY

Have you received, or are you currently receiving, psychotherapy/counseling services? YES NO

If so, please provide the name of the therapist or facility, address, date range in which you received treatment, and if possible, the type of therapy/therapies received.

Please provide as much of the requested information as possible.

The information in this section is very important as it is required for insurance authorization purposes

Name of therapist or facility:

_____

Address of therapist or facility:

_____

Date range of treatment:

_____

Type of therapy provided:

_____

Name of therapist or facility:

_____

Address of therapist or facility:

_____

Date range of treatment:

_____

Type of therapy provided:

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Name of therapist or facility:

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