BrainStim CENTERS

28212 Kelly Johnson Pkwy., Suite# 215, Valencia, CA 91355
16260 Ventura Blvd., Suite #700, Encino, CA 91436
P 310-895-7122 F 818-475-1433
www.brainstimcenters.com

PATIENT REGISTRATION FORM

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ E-Mail:_____

Male ☐ Female ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Domestic Partner ☐

Social Security # _____ Driver's License # _____ DOB _____ Age _____

Occupation _____Employer_____

Emergency Contact _____ Phone _____
(Name and Phone # of Relative or Friend not residing with you)

Referring Physician _____ Referring Physician Phone # _____

Primary Care Physician (PCP) _____ PCP Phone # _____

INSURANCE INFORMATION – MUST BE FILLED OUT IN FULL ALONG WITH A COPY OF YOUR INSURANCE CARD

Primary Insurance Company _____ Subscriber ID _____

Group ID _____ Subscriber name _____

Relationship to the patient _____

Secondary Insurance Company _____ Subscriber ID _____

Group ID _____ Subscriber name _____

Relationship to the patient _____

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MEDICAL AND PERSONAL INFORMATION

Please describe the medical problem or reason for today's visit: _____

Current Medications:

_____

_____

Allergies to Medications: _____

Please list all of your medical conditions _____

_____

Previous or other medical problems _____

Please list any previous surgeries or hospitalizations, including live births and miscarriages.

_____

Are you pregnant? ◯ Yes ◯ No

Planning a pregnancy? ◯ Yes ◯ No

Nursing a child? ◯ Yes ◯ No

Do you smoke? ◯ Yes ◯ No ◯ Cigarettes ◯ Pipe ◯ Cigars ◯ Vape

If yes, how many years _____ How much per day _____

Interested in quitting ◯ Yes. ◯ No

Do you drink alcohol? ◯ Yes. ◯ No

If yes, how many ounces/ drinks per day _____

Do you drink coffee? ◯ Yes ◯ No

If yes, how many cups per day _____

How did you hear about our office?_____

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PATIENT RESPONSIBILITY POLICY

Patient Responsibility Policy Patient Initial _____

Please know that patients are responsible for knowing which facility is participating with their insurance carrier in regard to hospitals, outpatient testing, labs, etc. The purpose of this policy is to ensure all patient financial responsibilities are collected in a timely manner. Please know your financial responsibilities.

Authorizations Patient Initial _____

Authorization will be required prior to the TMS treatment. If you are a new patient, please remember that it is your obligation to request an authorization from your referring physician. Authorization to see our physicians as follow up care will be obtained by your referring doctor. We would like to politely inform you; authorization can take up to 2-3 weeks.

Copayments Patient Initial _____

If you are not prepared to make your copay, your appointment will be rescheduled. If your insurance does not pay 100% you are responsible for paying the remaining balance before each visit. If you are self-pay, all visits will require 50% up-front payment at the time of the first treatment.

Eligibility Patient Initial _____

In the event you seek medical care at BrainStim Centers, Inc. and are not eligible with your insurance carrier or medical group at the time of service, please know that you will be held financially responsible for all charges.

Missed/ Cancelled Appointments Patient Initial _____

A $25.00 charge will be applied to missed appointments and appointments cancelled without 24 hours' notice. Appointment reminders are done as a courtesy only and do not constitute a timely phone call or failure to appear. You can adjust your appointments through our patient portal at www.brainstimcenters.com. Please check the patient portal tab, provide your information and choose different appointment time or give us a call.

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INSURANCE POLICY

Thank you for choosing BrainStim Centers, Inc. as your TMS clinic. We are committed in providing the highest quality and efficient health care. Please familiarize yourself with our policies and procedures to ensure you know your responsibility as a patient.

INSURANCE Plans Patient Initial _____

To meet the needs of our patients, we participate in various Insurance programs. Each insurance company has its own specific guidelines regarding the level of care and patient financial responsibility. Please understand that Insurance billing can take up to 3 weeks to process. Please read and initial next to your category of insurance listed.

HMO Plans Patient Initial _____

All co-pays must be satisfied each and every visit. This is due to contracting and compliance rules. You are responsible for getting proper co-pay information in advance of your appointment.

PPO Plans Patient Initial _____

We have agreed to accept the discounted rate from your Insurance plan however, all co-insurance is your responsibility. After your primary insurance has paid, we will send you a statement for the remainder applied to your responsibility by your insurance carrier.

MEDICARE Patient Initial _____

After your Insurance has cleared, we will send you a statement for the co-payment you are responsible for.

SECONDARY INSURANCE Patient Initial _____

Having more than one insurance does not necessarily mean that your services are covered 100%. As a courtesy we will bill your secondary insurance carrier however, you are responsible for any balances after your insurance has paid.

OUT OF NETWORK PPO Plans Patient Initial _____

We will bill your Insurance carrier as a courtesy. In the event charges are applied to your responsibility by your insurance carrier, we will bill your directly.

Please be sure to tell us when any of the following occur:

1. **You changed insurance companies**
2. **You changed plans within the same insurance company**
3. **You changed your home address and phone number**

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HIPAA

The federal government has mandated that every patient in the practice sign a form acknowledging that they know that a privacy policy is available. This privacy policy is known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and it details how we can use your medical information. The office staff has training in medical privacy matters, and we make every possible effort to ensure that your medical information is kept private and is used appropriately.

Please be assured patient privacy will be regarded with the utmost importance. Our employees signed a statement of confidentiality before they began working at BrainStim Centers, Inc. It is our intention to abide accordingly to the Federal Government Regulations known as HIPAA.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize BrainStim Centers, Inc. to convey to any physician and/or any medical facility directly involved with my care, my medical history, laboratory reports, MRI, and any other material services, consultations and treatments which I received while under his/her care.

Patient name _____

Signature _____ Date _____

The signature below indicates patient above received the HIPAA notice of privacy practices of BrainStim Centers, Inc.

Patient signature_____Date_____

Person Financially Responsible if Patient is a Minor

Name _____ DOB _____ Phone _____

Address_____

City _____ State _____ Zip _____

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PATIENT RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

1. I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered services.
2. Co-payments are due at time of service.
3. If my plan requests a referral, I must obtain it prior to my visit.
4. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize a direct payment of my medical benefits to BrainStim Centers, Inc. on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize BrainStim Centers, Inc. to release to my insurer, governmental agencies, Nexstim, Inc. (for depression registry) or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral from other medical provider.

MEDICARE REQUEST FOR PAYMENT

I request payment of my authorized Medicare benefits for any services furnished to me by BrainStim Centers, Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Date