LIGHTHOUSE PSYCHIATRY
ADVANCED TMS & COUNSELING
a beacon for recovery and discovery
Tel: (480) 565-6440 Fax: (480) 454-1085 TMS@LHpsych.com
www.LighthouseTMS.com

COMPLETE FORM TO SCHEDULE WITH A PROVIDER

Please complete ALL fields below. Email this form and supporting documents to SUPPORT@LHPSYCH.COM.

First Name:	Last Name:	Date of birth:
Email:	Phone:	
Home Address:		

PLEASE CONFIRM (by checking box). I understand that Lighthouse providers DO NOT provide any forensic psychiatry or therapy mandated by court order or state professional licensing boards, in which, any evaluations will be used as material items for future court or board hearings.

☐ **Yes. I acknowledge, understand and accept statement.**

PLEASE CONFIRM (by checking box). I understand Lighthouse accepts Medicare, but services are limited to select providers and scheduling availability may be limited.

☐ **Yes. I acknowledge, understand and accept statement.**

PLEASE CONFIRM (by checking box). I understand that Lighthouse providers DO NOT have a contract with AHCCCS, Mercy Care, or any Medicaid plans.

☐ **Yes. I acknowledge, understand and accept statement.**

PLEASE CONFIRM (by checking box). If it is determined on initial intake or subsequent follow-up appointments that the above statement are violated, I understand I will be discharged from provider/facility because the needed services and support is outside provider's/facility's scope.

☐ **Yes. I acknowledge, understand and accept statement.**

PLEASE select ONE that applies to you.

☐	I want to be SELF-PAY (no AHCCCS/Medicare/Commercial insurance).
☐	I want to use COMMERCIAL insurance (non-EAP).
☐	I want to use COMMERCIAL insurance (EAP).
☐	I have AHCCCS but will not use it. I want to be SELF-PAY for THERAPY (non-medication visits).
☐	I want to use MILITARY insurance (TriCare, TriWest).
☐	I want to use HB2502 benefits.

PRIMARY Insurance (Commercial, Non-EAP):		Phone:
Address:		
Member ID:	Group No:	
Subscriber Name:	Date of birth:	Relationship:
SECONDARY Insurance (Commercial, Non-EAP):		Phone:
Address:		
Member ID:	Group No:	
Subscriber Name:	Date of birth:	Relationship:

Additional FUNDING SOURCE(S) paying for office visit (ie. Vouchers, Grants)

☐	NONE
☐	SCHOOL VOUCHER
☐	LALOBOY FOUNDATION VOUCHER
☐	OTHER VOUCHERS (explain below

Patient is a MINOR (<18 years old)? (If minor and parents divorced or guardian, please upload custody documents along with this form)

☐	NO, I am an adult.
☐	YES, minor has MARRIED parents.
☐	YES, minor has DIVORCED parents with JOINT CUSTODY. (must provide court-ordered custody documents)
☐	YES, minor has DIVORCED parents with SOLE CUSTODY. (must provide court-ordered custody documents)

Patient has ACTIVE or PENDING legal case? (NOTE: Our providers typically do not appear in court. But if need be and coordination with court is required, then a fee will be charged to patient.)

	NONE. I have no active/pending legal case.		YES. Personal Injury (explain below)
	YES. Workman Comp (explain below)		Other (explain below)
	YES. Custody Court (explain below)		

Who referred you or source of referral? (List ALL)

Type of Provider(s) Needed (select all that applies)

	PSYCHIATRIST [for TMS/MeRT]
	PSYCHIATRIST [for AUTISM treatment with MeRT]
	PSYCHIATRIST [for IV KETAMINE INFUSION]
	PSYCHIATRIST [for ADHD]
	PSYCHIATRIST [for medications] (Age 1-65 years)
	PSYCHIATRIST [for medications] (Age 66+ years) (list all your medical conditions below)
	THERAPIST/COUNSELOR [Individual]
	THERAPIST/COUNSELOR [Trauma/PTSD]
	THERAPIST/COUNSELOR [Couples]

If you are age 66 and older, please list ALL ACTIVE MEDICAL (non-psychiatric) conditions currently managed by another doctor.
(Put "NONE" if not applicable)

**COUPLES/MARRIAGE/FAMILY THERAPY: Who will accept responsibility as the “chart holder” of records?

**COUPLES/MARRIAGE/FAMILY THERAPY: Who will accept financial responsibility?

Reason(s) for Appointment (select ALL that applies)

	TMS (Transcranial Magnetic Stimulation)		Concussion/TBI/Brain Injury
	MeRT (Magnetic e-Resonance Therapy) (EEG-Guided Advanced TMS)		Depression
	IV Ketamine Infusion		Anxiety
	QB Testing (for ADHD)		DBT (Dialectical Behavioral Therapy)
	Individual (Adult)		CBT/ACT/Mindfulness
	Individual (Child/Adolescent)		Personality Disorder (ie. Borderline)
	Marriage/Couples		Behavioral/School issues
	Family		Foster/Adoption Support
	PTSD/Trauma Therapy - EMDR		Recent Suicidal Ideation
	PTSD/Trauma Therapy - ART (Accelerated Resolution Therapy)		Veteran (using Tricare or Triwest)
	Autism (ASD)		First Responder needs (HB2502)
	ADHD/Attention/Hyperactivity/Concentration Issues		OTHER (comment below)

Patient is in ACTIVE treatment for SUBSTANCE ABUSE? (select ONE)

	YES, currently in INPATIENT detox treatment program
	YES, currently in OUTPATIENT substance treatment program (MAT, substance IOP, taking Methadone or Suboxone or Subutex)
	NO, discharged from detox program LESS THAN 30 days
	NO, discharged from detox program MORE THAN 6 months
	NO, NEVER undergone, referred for, or refused detox treatment for substance abuse

Patient is ACTIVELY using the following substance(s) WITHOUT a prescription? (select all that applies)

	NONE
	Alcohol (daily use)
	Marijuana
	Ecstasy, MDMA
	Methadone, Amphetamine
	Cocaine, Heroin, Crack, LSD, Hallucinagens
	Opioid/Pain Medication (Fentanyl, Morphine, Oxycodone (Percocet), Dilaudid, etc)
	Benzodiapine (Xanax, Valium, Ativan, Klonipin, Tamazepam)
	OTHER (comment below)

Patient is interested in the following ADVANCED treatment(s)?

	TMS (Transcranial Magnetic Stimulation)
	MeRT (Magnetic e-Resonance Therapy) – EEG-Guided Advanced TMS Therapy
	I.V. Ketamine Infusion
	None

<>ADVANCED Treatment: Patient has been DIAGNOSED with?

	Major Depression Disorder (MDD)
	Generalized Anxiety Disorder (GAD)
	Bipolar I/II Disorder (BP)
	Posttraumatic Stress Disorder (PTSD)
	Concussion/TBI/Brain Injury
	Autism (ASD)
	Postpartum Depression (PPD)
	Other (Explain below)

<> ADVANCED Treatment: Patient has tried ANTIDEPRESSANT medications? (Please explain below)

	0 antidepressant medication
	1-2 antidepressant medication
	3-4+ antidepressant medications
	Ketamine infusion/Spravato

<> ADVANCED Treatment: Patient has tried TMS, ECT, and/or Ketamine in the past?

	YES, TMS helped my symptoms.
	YES, ECT helped my symptoms.
	YES, IV Ketamine helped my symptoms.
	YES, but not effective.
	NO

<> ADVANCED Treatment: Any presence of non-removable metal in head (such as, , , , , , etc)?

	NONE
	Metal fragments
	Aneurysm clips
	Skull plates
	Cochlear implant
	Deep brain stimulator implant
	Vagal nerve stimulator implant

<>TMS question: Has patient experienced a seizure?

	NONE
	YES. 1-5 seizures in past year
	YES. I have history of chronic seizures or diagnosed with epilepsy requiring seizure medication. (TMS is contraindicated)

Additional Information (Please provide brief description of your needs, situation or any information to clarify answers above.)

Along with this form, please email us the following:

1. ***insurance card (FRONT & BACK)***
2. ***photo ID (FRONT & BACK)***
3. ***court custody documents (minor with divorced parents or guardians)***
4. ***any other supporting materials***

Please email to SUPPORT@LHPSYCH.COM Once received, a team member will review and continue you to schedule your appointment.