Uptown Psych

4753 N. Broadway St. Suite 403
Chicago, IL. 60640
820 Davis St, Suite 222
Evanston, IL 60201
Phone: 773-989-2780
Fax: 773-989-2781

CONSENT TO BE CONTACTED FOR POST-VISIT SATISFACTION SURVEY FORM

Patient First Name:_____

Patient Last Name:_____

Patient Date of Birth: _____

Uptown Psych is committed to ensuring patients' satisfaction of services received. Center has contracted with a third party – Burke, Inc. – to conduct satisfaction surveys on our behalf. The survey will be provided online and will take no more than 10 minutes to complete. If you agree to be contacted to participate in a survey about our services, please indicate your consent by checking one of the boxes below:

☐I agree to be contacted by Burke, Inc. via email (at the email listed below) for purpose of the survey and understand that the invitation will mention Center. I acknowledge and agree that these messages, which may contain Protected Health Information, will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Email Address: _____

I understand that this consent may be withdrawn by me at any time via the email I receive from Burke, Inc., via telephone by calling **773-989-2780** or via email message at **info@uptownpsych.com** I understand that my withdrawal of consent to be contacted for a post-visit satisfaction survey shall not withdraw my consent to otherwise by contacted by Center.

☐I do not wish to be contacted for purposes of this survey.

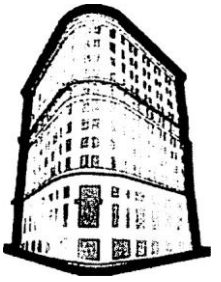
Signature

I confirm that I have read and fully understand the above information prior to my signing and all of my questions regarding this form have been answered to my satisfaction. I agree that I am signing this Consent to be Contacted for Post-Visit Satisfaction Survey Form freely and voluntarily. I understand that my consent given with my signature below will remain in effect unless and until I cancel such consent in writing pursuant to the terms set forth above.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient (or Responsible Party): _____

Responsible Party's Relationship to Patient: _____



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Intake Form

Patient _____ Name: _____

Date of Birth:_____

Legal Name (if different from above)

_____

SSN: Birth Gender_____Gender Identity_____

_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Physical Address

_____

City: State: Zip Code:

Is Mailing Address the same? Yes ☐ No ☐

Mailing Address

_____

City: _____ _____ . _____

State; Zip Code

Telephone: Email:

_____ _____

Insurance Information (Patients under 26 that have insurance under parents, please sign ROI form for billing communication)

Insurance Provider: Identification #:

Group #: Policy Holder Name

Policy Holder DOB Policy Holder SSN

Secondary Insurance:

Insurance Provider: Identification#:

Group #:

From whom or where do you receive your primary medical care?

From whom or where do you receive your primary medical care?

Clinic[Doctors Name:

Phone: Address:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ Yes No ☐

If Yes, by whom:

Emergency Contact

Name: Relationship:

Telephone Number:

Pharmacy Information

Name:

Address: Telephone Number:

How did you hear about us:

Would you be interested in learning more about trans-cranial magnetic stimulation (TMS), an FDA cleared, non-drug, side-effect free treatment for depression?

Yes ☐ No ☐

Office Financial Policy

Self-Pay Discounted & Out of Network Services Only:	Discounted Self Pay Fees	Out of Network Fees
Initial psychiatric evaluation -- up to 60 minutes	$400	$1100
Follow up psychiatry appointment -- 15-30 minutes	$175	$705
Initial therapy service -- up to1 hour	$135	$627
Therapy service – up to 1 hour	$135	$529
Group therapy – up to 1 hour	$80	$96
Family/Couples therapy -- up to 1 hour	$135	$357
Spravato treatment	$362	$312

Miscellaneous Fees:	
Initial visit no show fee	$150
Follow-up no show fee	$100
Lost controlled substances prescriptions	$25
Refill (Future appointment must be scheduled)	$15
Letters or medical records	$20-$150

Office Financial Policy:

- Self-Pay Policy: I understand that I am being offered a self-pay discounted rate for services as I do not have insurance that has in or out of network coverage.
- Out of Network Policy: I understand that I am responsible for the full billing charge unless the office states otherwise. The office will submit my visit to insurance for pricing. If any difference in charges is found after the claim has processed, the office will bill/refund me.
- Refunds: Refunds are only issued via refund check. Refunds can take up 45 days to receive.
- Request For Itemized Receipts: I understand it can take up to a week to be provided an itemized receipt.

Signed _____ Date _____

Patient/Guarantor

_____ By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above

Office Financial Policy

Cancellation/Missed Appointment Policy:

- Failure to show up to an appointment without 48 hours' notice will be subject to a $150.00 (initial) or $100.00 (follow up) charge.
- Cancellations made at the time or after a scheduled appointment will be considered as a missed appointment and card on file will be charged.

Individual Financial Responsibility:

- Uptown Psych will verify benefits prior to an appointment but a quote of benefits is not a guarantee of payment.
- I understand that the amount that is calculated at the time of my appointment is an estimate and depending on what is billed by my provider, there might additional be credit or balance after the service.
- I understand that it is my responsibility to provide the office with any changes of insurance coverage prior to my visit or I will be charged the self-pay rate until benefits are verified. ● I understand that 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.
- I understand that copays/deductible/coinsurance are due at time of service and any outstanding balances need to be paid prior to being seen.
- I understand that if payment cannot be made, my current/future appointments will be cancelled until full payment is received.
- I understand that I am financially responsible for any copay, deductible, coinsurance or non-covered service and may be contacted by email or phone call/text message.
- I understand that Providers may access records for administrative reasons.
- I consent to electronic signature with credit card swiped.

I agree that refunds will be sent by check and the process can take up to 45 days I authorize Uptown Psych to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays, deductibles and/or coinsurance after all attempts Uptown Psych has made in collecting the balance.

Signed_____ _____

Phone Consultation & Documentation Requests Policy

As a reminder, phone calls to your provider should be for emergency purposes only. All other matters are best discussed in session. In order to provide you with the best care, with your permission, our clinicians may communicate with other providers or collect outside information.
At times, this information may be beneficial and inform your treatment.
Scheduling an appointment with one of our psychotherapists to complete any ancillary paperwork or discuss collateral information is highly recommended. For our psychiatrists, appointments for these purposes are absolutely required. Please note, phone contact that our psychotherapists have with outside providers and paperwork completion time are not payable by your insurance company. These services may be billed directly to you from the fee schedule below.
Requests for documentation are granted on a case-by-case basis at the sole discretion of your provider. Typically, several sessions and consistent engagement in treatment is required for a provider to feel comfortable providing documentation of any kind. Beneficial information sources by phone include, but are not limited to:
Outside providers such as past individual therapists or Psychiatrists, group therapy counselors, social workers, and psychological testing specialists. For minors, teachers, school psychologists or social workers, and Individualized Education Plan or 504 involved specialists can also be helpful.

Documentation requests can include, but are not limited to:

Clinical summaries of diagnostic impressions or treatment plans, FMLA (Family Medical Leave Act) paperwork completion, background check documents for employment, bariatric surgery candidate requirements, letters to verify work absences for mental health reasons, documentation to show attendance of mental health appointments (sometimes required for court ordered treatment and minors involved with Department of Child and Family Services), disability paperwork, and summaries of clinical recommendations or impressions as requested by outside medical professionals.

Rates for phone consultation: $75.00 Rates for documentation completion: $60.00

Signed _____ Date _____

Credit Card on File Form

Uptown Psych requires that you provide a **credit card** on **file** with our office. **Credit Cards on file** will be used to pay account balances and Credit **cards** will be charged at the time of service for your patient responsibility.

Visa MasterCard Amex Discover

Card Number _____

Expiration Date _____

CVV Code _____

Name on Card _____

Address _____

Zip Code _____

I understand that this form is valid without expiration unless I cancel in writing.

Signed _____ Date _____

Patient/Guarantor

Email Policy

To better serve our patients, this office has established an email address for some form of communication. For routine matters that do not require response, please feel free to contact us at info@uptownpsych.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 12 hours. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property, and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

_____I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.

_____I understand and agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____ _____

Patient signature Witness (optional)

_____

Date

Email Policy

When requested this office will communicate some forms of information via email. This medium will be used with an eye towards medical and legal prudence.

- Email communications will only be used with established patients.
- Patients who elect to use email must be advised of this office's email policy and sign an informed consent (see attached).
- A copy of the consent will be given to the patient, if requested and another copy will be filed in the patient medical record. ● Email communications are restricted to conditions and situations which do not require immediate attention (see consent).
- Protected health information [PHI] will be transmitted in a secure format to render the information unusable, unreadable or indecipherable to unauthorized individuals. http://csrc.nist.gov/publications/nistpubs/8()()-66-Revl SP-80()-66-Revision I .pdf
- Email communications are a permanent part of the patient medical record. They should be retained in the paper record and/or electronically consistent with the Illinois medical records retention rules http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000850K6.17
- When a patient request has been completed, the staff member responsible for completing that task will be responsible for sending a confirmation message to the patient.
- As with any form of medical record documentation, unprofessional remarks or comments in email communications arc prohibited.
- Confidentiality of patient information will be maintained at all times to protect the integrity of patient-identifiable information.
- When sending patient information via email, the sender is expected to double check all "To" fields before transmitting.
- Maintaining a master list of patients email addresses is discouraged.
- Outgoing messages will contain discreet subject headers and a banner of the top of each message stating, "This is confidential medical communication."
- Each desktop workstation will have a password protected screen saver.

_____ _____

Patient signature Witness (optional)

_____

Date

HIPPA Consent

This form is an agreement between you and Uptown Psych. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

_____

When we examine, test, 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 in our office to decide on what treatment is best for you and provide treatment to you. We may also share this inforrnation with others to arrangc payment for your treatmcnt, to help carryout certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how wc use your information, how we share your information, and may change our notice of privacy practices. If wc do changc it, you can gct a copy from our website, www.uptownpsych.com, or by calling us at (773) 989-2780. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing and have it submitted to us. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____

If Patient is under 18 years of age:

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: Relationship to Patient: _____

Patient Responsibilities

All required patient forms must be completed and returned to front office staff before the time of your appointment; otherwise, the appointment may need to be rescheduled.

1. Patients are responsible for knowing what medications they are currently taking when scheduling an appointment. Some practitioners may not be able to provide certain medications and patients should be aware of this in advance.
2. Individual practitioners also may have different limitations and restrictions as to what they are able to prescribe with regards to controlled substances. These policies may be further outlined in the accompanying paperwork. If provided in advance, it is the patient's responsibility to be familiar with these policies as they will not change during the course of the appointment.
3. If additional paperwork is being requested from the provider such as FMLA, short term disability, emotional support animals, court documents etc., it is the patient's responsibility to discuss this in advance, provide the appropriate forms, and understand that certain requirements may need to be met for the provider to fill out such forms, and understand that certain requirements may need to be met for the provider to fill out such forms, if bale to do so at all. Before being considered for such requests, patients need to be established (e.g. have been seen for multiple appointments with engagement in care). In addition, paperwork completion is subject to additional fees varying from $25 to $200.
4. Missed appointments and cancellations less than 48 hours in advance, including initial evaluations, will be subject to a standard cancellation fee. The cancellation fee may be waived one time for an excusable or emergency situation, at the discretion of the provider. All subsequent missed appointments or cancellations (less than 48 hours in advance) will be subject to the standard fee without exception. Missed appointments beyond the third may result in transfer of care or care termination of the case as patients are expected to maintain appropriate follow up care as recommended by their provider.
5. Arrival to an appointment either in-person or virtual should be made in a timely manner. Beyond a certain period, your appointment may need t be rescheduled as having a significantly shorten appointment may not be therapeutic to treatment, and providers make their best efforts to provide each patient with their allowed time so as not to take away from the time of the next scheduled patient. Your appointment may need to be
   rescheduled if you arrive more than 10 minutes late to an intake appointment or more than 5 minutes late to a follow up appointment.
6. Refills for medications are completed during appointment times. Parents are responsible for scheduling follow up appointments in a timely manner such as they do not run out of medications. For all refill requests outside of appointments, patients are required to have an upcoming appointment scheduled. A partial refill until the upcoming appointment may be considered at the discretion of the provider, subject to a $20 charge.

7. **Providers may take 48 hours (2 business days) to return messages and phone calls.** If it is an urgent matter or an emergency, please call 911 or go to the emergency room.
8. If a patient has not been seen for 6 months or more, they will be considered inactive and their case at Uptown Psych will be closed.
9. If patients email their providers, they should send a separate email regarding each matter and not send multiple emails regarding same issue.

Patient signature _____

Date _____

Patient Information and Consent Form for Telepsychiatry

This consent form for telepsychiatry is entered into on _____ (date) by _____ (patient) and _____ (Uptown Psych Treating Provider)

Introduction

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist or nurse (provider) and the patient are not in the same location. The interactive electronic systems used in telepsychiatry incorporate network and software security protocols (encryption) to protect the confidentiality of patient information and audio and visual data.

Potential Benefits of Telepsychiatry

- Increased accessibility to psychiatric care.
- Patient convenience.

Potential Risks with Telepsychiatry

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by your Uptown Psych Treating Provider
- Your Uptown Psych Treating Provider may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or range for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, (although extremely unlikely) causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face-to-face visit but not in telepsychiatry session may result in errors in medical judgment.

Alternatives to the use of Telepsychiatry

- Traditional face to face sessions in your Uptown Psych Treating Provider's office.

Confidentiality Standards required for Telepsychiatry

- During a tele mental health session, both locations shall be considered a patient examination room regardless of a room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
- Rooms shall be designated private for the duration of the session with the Doctor and no unauthorized access shall be permitted.
- Both sites shall take every precaution to ensure the privacy of the consult and the confidentiality of the patient. All persons in the exam room at both sites shall be identifiable to all participants prior to the consultation and the patient's permission shall be obtained for any visitors or clinicians to be present during the session.
- HIPAA confidentiality requirements apply the same for telepsychiatry as for face-to-face consultations.

My Rights

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2. I understand that the video conferencing technology used by my Uptown Psych Treating Provider is encrypted to prevent unauthorized access to my private medical information.
3. I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time. Understand that my withdrawal of consent will not affect any future care or treatment.
4. I understand that my Uptown Psych Treating Provider has the right to withhold or withdraw their consent for the use of telepsychiatry during my care at any time.
5. I understand that all rules and regulations which apply to the practice of medicine in the state of Illinois also apply to telepsychiatry.
6. I understand that my Uptown Psych Treating Provider will not record any of our telepsychiatry sessions without my prior written consent.

My Responsibilities

1. I will not record any telepsychiatry sessions without prior written consent from my Uptown Psych Treating Provider.
2. I will inform my Uptown Psych Treating Provider if any other person can hear or see any part of our session before the session begins. My Uptown Psych Treating Provider will inform me if any other person can hear or see any part of our session before the session begins.
3. I understand that third parties may be required to join in the meeting with my doctor and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for video conferencing, I may forfeit my option to use telepsychiatry.
4. I understand that I, not my Uptown Psych Treating Provider, am responsible for the configuration of equipment on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third-party (Secure Telehealth) for technical support to determine my computer's readiness for telemedicine prior to beginning tele psych sessions with my doctor.
5. I understand that I must be a resident of the state of Illinois to be eligible for telepsychiatry services from my Uptown Psych Treating Provider

Patient Consent to the use of Telepsychiatry have read and understand the information provided above regarding telepsychiatry and have discussed it with my Uptown Psych Treating Provider and all of my questions have been answered to my satisfaction.

Signature of Patient (or person authorized to sign for patient):

Full name _____ Signature_____ Date: _____

I authorized signer, relationship to patient: _____

_____

Uptown Psych Treating Provider

PLEASE COMPLETE IF YOU ARE SEEING DR. LAM, DR. SHARMA, OR DR. MAI NGUYEN

Controlled substances are medications which include, but are not limited to the following:

- Certain sleep medications (Ambien, Lunesta, Sonata, etc. and their generics)
- Benzodiazepines (xanax, ativan, valium, librium, klonepin etc and their generics) • Stimulants (Adderall, vyvanse, concerta, ritalin, modafinil etc and their generics)
- Suboxone – Provider is not licensed to prescribe and thus does not prescribe.

Updated Controlled Substances Policy:

1. Provider does not prescribe multiple controlled substances to any patient. If you are taking more than one of these medications, it is your responsibility to have a primary care doctor or alternative provider to continue the other prescription. It will not be filled by provider during the course of treatment at any time.

2. All patients are required to complete and provide documented results of completed neuropsychological testing prior to starting any stimulant medication. This is NOT the same as an ADHD evaluation, ADHD screening, ADHD test, etc. Anything else submitted will still require completion of neuropsychological testing before stimulants can be started. Resources are provided below.

3. Upon starting or continuing any controlled substance prescription, a 6 month trial period will begin at which time medications may be titrated to effective dosing within provider specified limitations (see below). During this 6 month period, the patient will be responsible for finding either a primary care or alternative provider to continue the prescription beyond the 6th month. These medications are not designed to be taken in perpetuity so while the Drs. acknowledges that a number of patients will benefit from long term usage beyond this period, it is not a regimen that they prescribe. There are many well established physicians who will gladly continue these prescriptions outside of the office that can be contacted.

4. Provider does not prescribe more than a 1 mg equivalent of any benzodiazepine for emergency or daily use. If you are currently taking or feel you will need more than this amount, please let the office staff know so that you can be transferred to an alternative provider to better fit your needs.

5. Provider does not prescribe more that 40 mg TOTAL daily of any stimulant medication. If you are currently taking or feel that you will need more than this amount, please let the office staff know so that you can be transferred to an alternative provider to better fit your needs.

6. If you are a patient who is being transferred from a provider within the practice and currently taking stimulants, you may be seen for up to a 3 month grace period for refills. Within this time period it is your responsibility to complete and submit neuropsychological testing as is required of any other patient.
Alternatively, you may use this time to establish care elsewhere to continue your prescription. Regardless, no more than 40 mg as described above will be provided, and after the third month, no prescriptions will be written without completed neuropsychological testing.

7. Prescriptions are written on a month-by-month basis and only for one month at a time. If a prescription or medications are lost, the patient may receive one emergency refill, but this will be up to the pharmacist's discretion to fill. No further emergency or early refills will be provided beyond this single instance.

8. These policies remain subject to change and do not constitute a guarantee that you will receive a controlled substance prescription at any point in time.

❑ I have read the above, understand, and agree to abide by the controlled substance policies as stated above by provider.

_____

Signature

NeuroPsych Resources

Please contact any of the following for **Neuropsychological Testing**:

Denise Fiduccia ADHD
Mary Schmidt ADHD
Athen's and Associates ADHD
Ellen Kraemer ADHD
George, Miller, White and Associates ADHD
Gersten Center for Behavioral Health ADHD
Belmont Depression and Anxiety Center
Kim Rubenstein, Psy.D. Center for Personal Development
Cognitive Solutions Learning Center Sharon Getz, Psy.D.
Frederick Bylsma Ph.D. Neuropsychological Services, P.C.

Psychologytoday.us

PSYCHIATRY HEALTH HISTORY FORM

Date:

Name:

Reason for visit today:

Past Medical History:

Current medical conditions:

Current medications:

Allergies:

Past Psychiatric History:

History: History of counseling/therapy: (Indicate when, where, name of counselor)

Previous trials of psychiatric medications:

Previous psychiatric hospitalization: (Indicate when and where)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "V" 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				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

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 ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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TMS Treatment

Welcome to Uptown Psych,

Here at our office, we offer a TMS (transcranial magnetic stimulation). This is a treatment that is reviewed by a psychiatrist and performed by a TMS technician. This treatment is also covered by most insurance companies.

HISTORY

TMS has been approved by the FDA for the treatment of depression since October 2008. The interest in magnetic fields started in the mid 1980's for evidence began showing they possessed potential therapeutic value.

The first controlled trials in North America started in 1999 and since then many subsequent trials and clinical experiences have further elucidated the therapeutic value of using Transcranial Magnetic Stimulation as a tool in the treatment of depression.

In December 2010 the American Psychiatric Association guidelines in the treatment of depression were modified to include TMS as an appropriate treatment to consider after failing at least one adequate trial of antidepressants.

HOW DOES IT WORK?

During a TMS treatment session, an electromagnetic coil is placed against your scalp near your forehead. The electromagnet painlessly delivers a magnetic pulse that stimulates the nerve cells; In the region of your brain involved in mood control and depression/anxiety. It's thought to activate regions of the brain that have decreased activity in depression. The stimulation appears to impact how the brain is operating, which in turn seems to ease depression symptoms and improve mood.

GET STARTED TODAY Please check the box below if you are interested in starting this treatment You can also visit our website **Uptownpsych.com** and fill out our **Treatment Resistant Questionnaire**.

☐ **Yes, I would like more information.**