BEACHES TMS
& BRAIN HEALTH

ALINA M GALLIANO-PARDO, MD, DABPN, DABAM
1909 BEACH BOULEVARD • SUITE 201
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DIRECT PHONE: 904•853•5867
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www.beachesdeeptms.com

SPRAVATO Evaluation Packet

Please fill out the following information and return it to our office at least 24 hours prior to your appointment. If at any point you have questions, concerns or feel overwhelmed, please call our office and we will be happy to assist you.

Initial Assessment

This assessment is a two-part process that involves a review of your medical history and then a second visit for your initial treatment. Your first appointment will last about an hour. The initial assessment, or consultation, will be used to evaluate the appropriateness of Spravato/esketamine in treating your depression. Dr Galliano-Pardo, your Spravato prescribing psychiatrist, will use the assessment to determine a diagnosis and the risks and benefits of Spravato compared to other available treatments for your diagnosis.

The doctor will also want details about previous treatment for your depression including counseling history, names of medications and maximum dosage, duration of treatment, and reasons treatment was discontinued, such as lack of benefit or side effects. You should be prepared to complete formal medical history evaluations and sign consent forms.

There is also a chance that Dr Galliano -Pardo will request a physical examination from your primary care physician. This is not always the case, though, and will vary from patient to patient. If a physical examination is requested, it will most likely be used to carefully screen patients for the presence of medical conditions that are contraindicated with Spravato.

At the end of the assessment, Dr. Galliano-Pardo will decide if you are a candidate for Spravato. If Spravato is right for you, she will create a treatment plan for you. Your next appointment will be your first treatment

Your first evaluation will be about 1 hours long. Your intake with a staff member will take about 15 minutes followed by a 45 minute to an hour meeting with Dr. Galliano-Pardo. Please review the information in the packet, and email them back to us at **least 24 hours prior to your scheduled appointment.** If your information is not received 24 hours prior to your appointment, your appointment may need to be rescheduled. If at any point you have questions, concerns, or feel overwhelmed, please do not hesitate to contact our office. The paperwork can be completed on your computer or printed, filled, and scanned. Also, please send us a copy of a **valid photo ID** and a photo of the front and back of your **insurance card** (primary and secondary) so that we are able to verify your benefits and co-payments prior to your appointment time. We will be able to begin working on the prior authorization for Spravato as soon as we receive this information

Typical Treatment Schedule

- Month 1: Two treatments per week
- Month 2: One treatment per week
- Month 3+: Continue weekly treatment Or Treatment once every 2 weeks

Office Policies

Contacting Us

Always remember: if you have a potentially life-threatening emergency and need help **IMMEDIATELY, CALL 911 or GO TO AN EMERGENCY ROOM.** You can contact us once the situation is stabilized.

For general questions or concerns you can call our office during hours listed above and speak to a staff member. Be prepared to give a detailed message to the staff member. They will consult with your physician and will call you back. If you chose to leave a detailed voicemail, please be aware that calls are returned within 24 business hours.

If you call after the office is closed you can leave a message and we will call you back on the next business day or you can also send us an e-mail to information@beachesbehavioral.com and expect an answer within 24-hours.

We will try our best to get back to you as soon as we can, but remember that urgent matters are handled first. If you have an urgent matter that **can't wait until the next business day**, please email information@beachesbehavioral.com to get a call back.

Office Hours

The Front Office and phone lines are open from 8 am-3 pm. Patient follow up appointments are Monday through Thursday starting at 7:30am and are every 30 minutes until 12:30pm.

Spravato Treatment Hours

The office is open for Spravato treatments from 8:00am- 3:00pm. If these times are not convenient for you, please contact our office for further discussion of possible options.

Appointments

All appointments need to be confirmed within twenty-four (24) business hours of the time scheduled. If your appointment is not confirmed, it is subject to being canceled and you will be charged the No Show or the Late Cancellation fee. It is your responsibility to come to your appointments on the correct date and time.

If you need to cancel an appointment you will need to do it with at least twenty-four (24) business hours' notice by calling or emailing our office or you will be charged the Late Cancellation fee. Late cancellation fees are as follows: $100 for Follow up appointments, $200 for New Patient appointments**,** and $50 for TMS treatment appointments**.**

Please be aware that we will need to obtain a CC on file to hold your appointment.

Electronic Communication Authorization

Beaches Deep TMS & Brain Health may communicate with me using electronic (Non-HIPPA compliant) communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to Beaches Deep TMS & Brain Health or that I have used to initiate contact with Beaches Deep TMS & Brain Health. These communications may include appointment information, protected health information and confidential information. I understand that these electronic communications are not encrypted. We use reasonable means to ensure security of communication with these methods, however we can not guarantee the security of non-HIPPA compliant methods.

◯ I Authorize Electronic Communication

◯ I DO NOT Authorize Electronic Communication

CONSENT FOR URINE DRUG SCREEN

Please Read Each Item

Your physician, Alina M. Galliano-Pardo, M.D., **may order** urine specimens to be collected for the purpose of drug screening at any time if it is deemed necessary. You will be tested upon admission and randomly during follow up visits at the doctor's discretion.

We **require** urine screening if you are taking controlled medication prescribed by this office. If you are taking **any controlled medication** including Buprenorphine (Suboxone/Zubsolv). If you refuse drug screening, you may not be allowed to see the doctor and your prescription may not be renewed.

You may refuse to provide urine for testing at any time. Your physician will be informed of this and could interfere with your participation in treatment at this office.

Most insurance plans **do not** pay for drug screening. If they don't, you agree to pay our $25.00 charge. Drug screening charges are already included in self-pay patient visit charges. Patients that come into the office for a drug screen outside of an appointment will be required to pay a $25.00 charge.

If your drug screening is positive and you believe this is an error, you can request the sample to be sent for confirmation to a certified lab. If your insurance does not cover the external lab charges, you will be responsible for payment of those charges.

Your signature below acknowledges that you have read and understand the policies of Alina M. Galliano-Pardo, M.D. Please check the appropriate box below indicating your informed consent.

- ○ I consent to having urine specimens collected for drug screening.
- ○ I **do not** consent to having urine specimens collected for drug screening.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

COVID-19 Informed Consent
Our office is taking all necessary steps and measures to insure the safety of our patients and staff. We are following all recommended CDC and state guidelines to help reduce the spread of COVID-19.

Telehealth Services
For your initial evaluation, you have the option between an in-person appointment or a telehealth appointment. Ongoing follow-ups will be via telehealth. Telehealth appointments are conducted through a HIPPA-compliant platform that requires video and audio capabilities. You will receive an email 24-48 hours before your appointment with instructions. If you have any questions or concerns please contact the office.
For your appointment(s), please make sure:

- You have the proper equipment- video and audio capabilities on a mobile device or computer
- You are in a quiet location with reliable service.
- If you are driving, please pull over to a safe location for the duration of your session.

Termination of Treatment
Dr. Alina Galliano-Pardo will deem treatment ineffective and advise a patient to seek treatment elsewhere when a patient's actions indicate that he or she has disengaged from treatment. Following are some examples of situations warranting termination of treatment:

- The patient misses two or more appointments
- The patient ceases paying for treatment
- The patient is noncompliant with treatment recommendations
- The patient misuses or abuses prescribed medications
- The patient behaves in an abusive, threatening or inappropriate manner toward staff, or other patients
- The patient fails multiple drug screenings (Suboxone or controlled medication patients)

Please check all that apply:

☐ I have reviewed and agree to the Policies of this Office.

☐ I have reviewed and agree to the UDS Consent Form

☐ I have reviewed and agree to the New Patient Registration/Insurance Form

☐ I have received and agree to the COVID-19 Informed Consent

☐ I have reviewed and agree with the Notice of Privacy Practice (Located on our website for your review)

I_____ have received, reviewed and agree with the terms of the Office and Financial Policies for Doctor Alina Galliano-Pardo.

_____ _____

Signature Date

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Card Holder Authorization for Credit Card Charges

Patient Information

Name of Patient: _____

Credit Card Information

First Name (as it appears on credit card): _____

Last Name (as it appears on credit card): _____

Relationship to Patient: _____

Credit Card Type ◯ **AmEx** ◯ **Discover** ◯ **MC** ◯ **Visa**

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____ **CCV Code:** _____

Credit Card Billing Address

Street/PO Box: _____

City: _____

State/Zipcode: _____

Billing Phone: _____

Acknowledgement

I authorize Alina M. Galliano-Pardo, M.D., P.A. to charge this credit/debit/HAS debit card for any and/or all co-payments, patient responsibility portions of my insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request, lost prescriptions, prescription refills, and missed/no-show or late appointment fees.

I certify that I am an authorized signer on the card provided and that the credit card number provided and signature below are the same as those on file with the credit card issuer.

_____ _____

Cardholder's Signature Date

_____

Printed Employee Name

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Providing information regarding your family members, friends, and other providers can be helpful in facilitating your care and ensures we are able to provide you with the best possible care. This form is optional and allows you to choose who you would like your informational potentially shared with.

I hereby authorize Beaches Behavioral to release/receive information from my medical record including general medical information as well as Acquired Immunodeficiency Syndrome and/or HIV tests, psychiatric, psychological, drug and/or alcohol records in compliance with Florida Statutes 90.503.394.459, 395.017, 396.112, 397.053 and Federal Regulation 42 CFR, Part 2. The type of information authorized for disclosure includes, but may not be limited to

Patient Name:		**DOB:**	**Initial each specific consent to release**
Family Members or Significant Others	Name/Relationship Name/Relationship Name/Relationship	**Purpose:** • To facilitate understanding and support in treatment. • To aid in diagnosis and continuity of care. **Type of information to be disclosed:** • All medical records ☐ • Progress Notes ☐ • Labs ☐ • Medications ☐ • Evaluations ☐ • Other: _____ _____	○ Yes ○ No _____ Initial
Mental Health Professionals	Psychiatrist Phone Therapist Phone		○ Yes ○ No _____ Initial
Primary Care Physician	Name/ Group Phone		○ Yes ○ No _____ Initial
Pharmacy			○ Yes ○ No _____ Initial
Other Specialists	Name/ Group/ Phone Name/ Group/ Phone Name/ Group/ Phone		○ Yes ○ No _____ Initial
Referrals			○ Yes ○ No _____ Initial

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I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to , diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the or use of my health care information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is release with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Beaches Behavioral Office, except to the extent that action has already been taken in reliance on it.

_____	_____
Patient Signature	Date
_____	_____
Guardian/ Representative	Date
_____	_____
Witness Signature	Date

PATIENT DEMOGRAPHICS

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Home Phone: Cell Phone:

Social Security Number: DOB: Gender: M ◯ F ◯

Marital Status: Ethnicity:

Employer Name:

Employer Address and Phone:

PRIMARY INSURANCE INFORMATION

Insurance Carrier: Policy ID: Group Number:

Policy Holder's Name: Group Name:

Policy Holder's DOB: Relationship to Patient:

Policy Holder's Social Sec Number:

Policy Holder's Employer:

Employer Address and Phone:

SECONDARY INSURANCE INFORMATION

Insurance Carrier: Policy ID: Group Number:

Policy Holder's Name: Group Name:

Policy Holder's DOB: Relationship to Patient:

Employer Address and Phone:

IF YOU HAVE A SECONDARY INSURANCE POLICY, IT IS YOUR RESPONSABILITY TO ADVISE THE STAFF WHICH IS THE PRIMARY AND WHICH IS THE SECONDARY INSURER. FAILURE TO DO SO MAY CAUSE SUBMISSION TO THE INCORRECT INSURANCE COMPANY. INSURERS HAVE TWO (2) YEARS TO RECOUP MONIES THAT HAVE BEEN DISPENSED IN ERROR, AND ONCE THE NOTICE OF RECOUPMENT IS RECEIVED, IT IS LIKELY THAT THE TIMELY FILING LIMIT FOR THE CORRECT INSURER HAS PASSED. IF THAT SHOULD HAPPEN, IT BECOMES THE PATIENT'S RESPONSABILITY FOR THE CHARGES INCURRED. PATIENT'S INITIALS:

EMERGENCY CONTACT INFORMATION

Emergency Name: Relationship:

Emergency Address: City: State: Zip:

Emergency Phone #1: Emergency Phone #2:

FINANCIALLY RESPONSIBLE PARTY INFORMATION

☐ Same as patient demographics

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Relationship to Patient:

Home Phone: Cell Phone:

Social Security Number: DOB: Gender: M ◯ F ◯

Employer Address and Phone:

DO YOU HAVE A HEALTH CARE SURROGATE OR A LEGAL GUARDIAN? YES ◯ NO ◯

Surrogate/Guardian Name: Relationship:

Surrogate/Guardian Address: City: State: Zip:

Surrogate/Guardian Phone #1: Surrogate/Guardian Phone #2:

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New Patient Medical History Form

Please complete all information on this form and email it to information@behavirolbeaches.com prior to your first visit. Please get it to our office **24 hours before** your scheduled appointment

Name_____

Email: _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

Pharmacy Name & Location _____ Phone #_____

Secondary Pharmacy _____ Phone# _____

Medical History

Do you have any known allergies? ◯ **Yes** ◯ **No**

If yes please explain:

_____

_____

Do you have any adverse drug reactions? ◯ **Yes** ◯ **No**

If yes please explain:

_____

_____

What are your other **non-psychiatric** medical diagnoses? (ie. Asthma, diabetes, high blood pressure etc.)

_____

_____

_____

_____

_____

_____

List ALL medications you are currently taking (**non-psychiatric**) including dosage and how often you take them. Please include everything you take from vitamins, OTC medications, and prescribed medications

Medication Name	Diagnosis	Daily Dose	How Often

Do you take your medication as prescribed? ◯ Yes ◯ No

List any non-psychiatric hospitalizations including year. (ie. Severe flu, stomach pain etc) If none write N/A

_____
_____
_____
_____

List any surgeries including type of surgery, location, and year

_____
_____
_____
_____
_____

Do you exercise regularly? ◯ Yes ◯ No
How much alcohol do you consume? _____
How many caffeinated beverages do you drink a day? Coffee_____ Soda_____ Other_____
Do you use recreational drugs ◯ Yes ◯ No If yes, which ones_____
Do you have trouble sleeping? ☐ None ☐ Yes, falling asleep ☐ Yes, staying asleep ☐ Both
On average, how many hours of sleep do you get per night? _____
Are there any sources of stress in your life? ◯ Yes ◯ No
If yes, explain:

_____
_____
_____

Do you use tobacco products? ◯ Yes ◯ No

If yes, what form and how often:

_____

Do you suffer from chronic pain? ◯ Yes ◯ No

If yes, include location, severity and timing of pain:

_____

_____

_____

Name of Primary care Provider: _____Last Seen: _____

Any other non-psychiatric providers currently being seen:

_____

_____

_____

_____

_____

_____

List any recent diagnostic testing (labs or imaging). Include type date and location where testing was done

_____

_____

_____

_____

_____

Have you received the COVID-19 Vaccine? ◯ Yes ◯ No

If you have: Date of 1st Dose: _____ Date of 2nd Dose:_____

If you have not received it, do you plan on getting it? ◯ Yes ◯ No

Past Psychiatric History

List any previous psychiatrists you have seen in the **last 5 years**, including years/dates of treatment, and treatment outcome.

_____

_____

_____

_____

_____

_____

_____

List any previous therapists you have seen in the **last 5 years**, including years/dates of treatment and treatment outcome

_____

_____

_____

_____

List any psychiatric disorders you have been diagnosed with including: the age you began treatment and which doctor gave you the diagnosis:

_____
_____
_____
_____
_____

List any psychiatric hospitalizations including the provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome

In the past, have you tried electroconvulsion therapy (ECT)? ◯ Yes ◯ No
If you answered yes, please complete the following questions:

Name of Facility _____
Dates: _____
Reason: _____
Number of Sessions _____
Outcome: _____

In the past have you tried Ketamine or Esketamine treatment? ◯ Yes ◯ No
If you answered yes, please complete the following questions:

Name of Facility _____
Dates: _____
Reason: _____
Number of Sessions _____
Outcome: _____

List any previous psychotherapy treatment including the provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome

List any Outpatient treatments including when, by whom and nature of treatment. Please also describe the outcome of the treatment

Reason	Dates/ Length	Provider Name	Outcome

In the past have you been suicidal or self-injurious? ( ) Yes ( ) No
In the past, have you ever made a suicidal attempt? ( ) Yes ( ) No
If yes, please indicate the year(s) it occurred

_____

_____

In the past, have you been assaultive towards someone else? ( ) Yes ( ) No
Do you have a history of substance abuse? ( ) Yes ( ) No
If yes, include what substance, when, how long, and date of last use:

_____

_____

_____

_____

Have you done a genetic testing for psychotropic medications (ie. GeneSight) ( ) Yes ( ) No
If yes, please send the office a copy of your results prior to your appointment.
If yes, what is the date of testing: _____

List any psychological/neuropsychological testing you have completed including the name of the provider, year, and reason for testing. **If you have, please send the office a copy of your results prior to your appointment.**

Name of Provider	Year	Reason

List any pharmacies you have used in the last **5 years.** Please include the name , location and phone number of the pharmacy.

Pharmacy Name	Location	Phone Number

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). When describing the reason stopped please indicate whether it was ineffective or if you experience side effects and if so, what side effects.

Antidepressants	Dates	Dosage	Reason Stopped
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

Mood Stabilizers	Dates	Dosage	Reason Stopped
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Typical Antiphsychotics	Dates	Dosage	Reason Stopped
Haldol (haloperidol)			
Loxitane (loxapine)			
Mellaril (thioridazine)			
Moban (molindone)			
Navane (thiothixene)			
Prolixin (fluphenazine)			
Serentil (mesoridazine)			
Stelazine (trifluoperazine)			
Thorazine (chlorpromazine)			
Trilafon (perphenazine)			

Past Psychiatric medications (continued)

Atypical Antipsychotics	Dates	Dosage	Reason Stopped
Abilify (aripiprazole)			
Clozaril (clozapine)			
Risperdal (risperidone)			
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Rexulti (Brexpiprazole)			
Vraylar (Cariprazine)			
Other			

Sedative/Hypnotics	Dates	Dosage	Reason Stopped
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

ADHD Medications	Dates	Dosage	Reason Stopped
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (Lisdexamfetamine)			
Other			

Antianxiety medications	Dates	Dosage	Reason Stopped
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Centrax (prazepam)			
Librium (chlordiazepoxide)			
Inderal (propranolol)			
Serax (oxazepam)			
Tenormin (atenolol)			
Hydroxyzine			
Other			

Has anyone in your family been diagnosed with a behavioral health disorder? ◯ Yes ◯ No

If yes, explain which family member?

Social History

Where were you born:_____

Who were you primarily raised by:_____

What is your birth order and how many siblings do you have? _____

How would you describe the quality of your childhood? _____

Were there any sources of family stressors growing up? _____

How is the relationship quality with your family member?

_____

_____

Education History

Have you received your high school diploma? ◯ Yes ◯ No

Have you received a GED certificate? ◯ Yes ◯ No

Have you attended college ◯ Yes ◯ No

Have you graduated from college ◯ Yes ◯ No

If so, please list area of study _____

Employment History

Occupation: _____

Length of Current position: _____

How would you describe your work quality?_____

Relationship/ Marriage

Are you currently married? ◯ Yes ◯ No

Length of current marriage? _____ Quality of current marriage? _____

How many times have you been married? _____

Children Information

Do you have any children? ◯ Yes ◯ No If yes, how many _____

Are they from your current marriage or previous marriage? _____

How is your relationship with your child/ children _____

Have you ever been in the Military? ◯ Yes ◯ No

If yes, include what branch, type of discharge (if applicable), and any trauma as a result:

_____

_____

Have you ever been arrested? ◯ Yes ◯ No

If yes, please explain:

_____

_____

_____

Who is currently in you support system?

_____

_____

FOR IN OFFICE USE ONLY

Reviewed by: _____ Date: _____

Janssen Patient Support Program
Patient Authorization Form

- **Patients should read the Patient Authorization, check the desired permission boxes, and return the form to Janssen Patient Support Program**
  - **Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed form and upload on Provider Portal, or completed form may be faxed to 833-777-7282 or mailed to Janssen CarePath, PO Box 13135, La Jolla, CA 92037**
  - **You may be able to eSign a digital form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

Patient Name _____ **Email** _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information.

My "Protected Health Information" includes but is not limited to the following information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, and contact me about Janssen patient support programs
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my Janssen medication, and to confirm to my Healthcare Provider that support has been provided by the Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen Patient Support Program
Patient Authorization Form

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, PO Box 13135, La Jolla, CA 92037.

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at https://www.janssen.com/us/privacy-policy#california

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient sign here: _____ Date: _____

If the patient cannot sign, patient's legally authorized representative must sign below:

By: _____ Date: _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

janssen

SPRAVATO® REMS

Patient Enrollment Form - Outpatient Use Only

This section is to be completed by the Patient

Your healthcare provider will help you complete this form and provide you with a copy.

**** Indicates required field***

Patient Information

First Name*:	MI:	Last Name*:	Birthdate*: (MM/DD/YYYY):	Sex*: ☐ Male ☐ Female ☐ Other

Email*: (Email is required for online enrollment only)	Phone Number*:
Address 1*:	Address 2:

City*:	State*:	ZIP*:

Patient Agreement

By signing this form, I understand and acknowledge that:

Before my treatment begins, I will:

- Enroll in the SPRAVATO® REMS by completing this *Patient Enrollment Form* with my healthcare provider. Enrollment information will be submitted to the SPRAVATO® REMS.
- Receive counseling on safety risks and the need for monitoring to observe for resolution of sedation and dissociation, and for any changes in vital signs.

During treatment, and after administration I will:

- Use the SPRAVATO® nasal spray myself under the direct observation of a healthcare provider.
- Be observed at the healthcare setting where I get SPRAVATO® for at least 2 hours after each treatment until the healthcare provider determines I am ready to leave the healthcare setting.

I understand:

- Sedation and dissociation can result from treatment with SPRAVATO® and I must stay after each treatment.
  Until these effects resolve, I may feel:
  - sleepy and/or
  - disconnected from myself, my thoughts, feelings and things around me.
- I should make arrangements to safely get home.
- I should not drive or use heavy machinery for the rest of the day on which I receive SPRAVATO®.
- I should contact my doctor or inform him/her at my next visit if I believe I have a side effect or reaction from SPRAVATO®.
- In order to receive SPRAVATO® as an outpatient, I am required to be enrolled in the REMS, and my information will be stored in a database of all outpatients who receive SPRAVATO® in the United States.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may contact me or my prescriber via phone, mail, fax, or email to support administration of the REMS.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may use, disclose, and share my personal health information for the purpose of the operations of the REMS, including enrolling me into the REMS and administering the REMS, coordinating the dispensing of SPRAVATO®, and releasing and disclosing my personal health information to the Food and Drug Administration (FDA), as necessary, and as otherwise required by law.

Patient Name (please print):	
Patient Signature*:	**Date*:**