BrainsWay Deep TMS™ Treatment Consent and Acknowledgment

Patient Name: _____ DOB: _____ Date: _____

I understand that Deep Transcranial Magnetic Stimulation (Deep TMS™) is a non-invasive treatment that uses magnetic pulses to stimulate areas of the brain associated with certain mental health conditions. The purpose of treatment, potential benefits, risks, and available alternatives have been explained to me. I understand that treatment results vary and cannot be guaranteed.

Potential side effects may include scalp discomfort, headache, facial muscle twitching, lightheadedness, fatigue, and temporary discomfort at the treatment site. Although rare, serious risks such as seizure may occur. I understand that I should immediately report any unusual symptoms or concerns to my treatment team.

I understand that treatment typically requires multiple sessions over several weeks and that adherence to the prescribed treatment schedule is important. I agree to inform my provider of any changes in my medical condition, medications, implanted devices, or other factors that could affect treatment safety.

I have had the opportunity to ask questions and have received satisfactory answers regarding the nature of the treatment, expected benefits, risks, alternatives, and treatment process.

By signing below, I acknowledge that I have read and understood this form and voluntarily consent to receive BrainsWay Deep TMS™ treatment.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____