AXIOS
BEHAVIORAL
HEALTH
"Courtesy, Compassion & Care"
UMARU LABAY-KAMARA M.D.

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Phone Number: (301) 934-3415
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ADOLESCENT

PATIENT REGISTRATION:

First:_____ **MI:**____ **Last:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____ **Work #:**_____

Employer:_____ **Last 4 Digits of SS#:**_____

Date of Birth:_____ **Age:**____ **Gender:**_____ **Marital Status:**_____

Race:_____ **Email:**_____

EMERGENCY CONTACT:_____ **PHONE:**_____

RELATION TO THE PATIENT:_____

Legal Guardian Information (If patient is under 18 years old)

Name:_____ **Relationship to Patient:**_____

Home #:_____ **Cell #:**_____ **Work #:**_____

Financial and Policy Holder Information:

Primary Insurance

Insurance Company:_____ **ID #:**_____ **Group #:**_____

Effective Date:_____ **Policy Holder Name:**_____

Last 4 of Policy Holder SS#:_____ **Date of Birth:**_____ **Relationship:**_____

Secondary Insurance

Insurance Company:_____ **ID #:**_____ **Group #:**_____

Effective Date:_____ **Policy Holder Name:**_____

Last 4 of Policy Holder SS#:_____ **Date of Birth:**_____ **Relationship:**_____

Behavioral Health Intake Form – Child & Adolescent

Child's Name		Today's Date
Address		Date of Birth
City	State	ZIP Code
Primary Telephone:		☐ home ☐ cell ☐ work
Alternate Telephone:		☐ home ☐ cell ☐ work

We were referred by:

Household Composition

Who lives in the primary residence with the child?

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Does the child live in a second home? ☐ Yes: How often? ☐ No

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Parents' Marital Status/Family of Origin

☐ Never Married	☐ Is the child adopted? If so, is child aware?
☐ Married/Civil Union	Siblings names & ages:
☐ Separated, when:	
☐ Divorced, when:	
☐ Widowed, when:	Other significant relationships:
☐ Remarried, when:	

Current Medications

Medication	Dates	Reason	Effectiveness

Child's Medical History		
☐ Asthma	☐ Bowel problems	Allergies:
☐ Recurrent ear infections/tubes	☐ Thyroid disease	
☐ Eye/Vision problems	☐ Diabetes (Type I/Type II)	
☐ EEG, MRI, or CT	☐ German Measles, Whooping Cough, Measles, Mumps, Scarlet Fever, Chicken Pox	Hospitalization:
☐ Headaches/Migraines		
☐ Meningitis/Encephalitis		Surgery:
☐ Seizures	☐ Lead/Toxic chemical exposure	
☐ Head injury/Concussion	☐ Irregular menstrual period	Other:
☐ Developmental delay	☐ Pregnant	
☐ Slow weight gain	☐	

Please check all that that have applied to your child in the past 30 days:		
☐ Can't concentrate/Pay attention	☐ Bedwetting/soiling self	☐ Sees/hears things that are not real
☐ Restless/Hyperactive	☐ Has been bullied	☐ Confused thinking
☐ Talks too much/out of turn	☐ Frequent sadness/irritability	☐ Feels people are "out to get" him/her
☐ Impulsive/Acts without thinking	☐ Tearful/Cries easily	☐ Odd/bizarre thoughts/behavior
☐ Trouble staying seated	☐ Low energy level	☐ Behaves like a younger child
☐ Makes careless mistakes	☐ Loss of interest in favorite activities	☐ Has trouble communicating
☐ Fails to finish things he/she starts	☐ Low self-esteem/Guilt	☐ Sensory experiences/issues
☐ Feeling irritable	☐ Dislike of his/her body	☐ Makes repetitive sounds/movements
☐ Daydreams/Gets lost in thought	☐ Feelings hurt easily	☐ Fascinated with parts of toys
☐ Inattentive/Easily distracted	☐ Has trouble making & keeping friends	☐ Is not affectionate
☐ Has trouble following directions	☐ Severe changes in mood	☐ Lack of imaginary/pretend play
☐ Forgetful/Often loses things	☐ Talks too much/fast/changes topic quickly	☐ Avoids/seems obsessed with certain things
☐ Police contact		
☐ Angry/Resentful	☐ Thoughts racing	☐ Does not seek to share interests
☐ Argues/Does not follow rules	☐ Inflated self-esteem	☐ Does not make friends/is in own world
☐ Annoys others purposely	☐ Difficulty controlling emotions	☐ Does not keep eye contact
☐ Bullies/Threatens/Intimidates	☐ Worries about safety of self/others	☐ Rituals/routines must be followed
☐ Physical aggression	☐ Unusual worries/fears	☐ Needs little sleep (rested after 3-4 hours)
☐ Has set fires	☐ Panic attacks	☐ Cannot fall asleep even though tired
☐ Stealing/Shoplifting	☐ Obsessive thoughts	☐ Problems staying asleep/Nightmares
☐ Temper tantrums/Loses temper easily	☐ Panics when separated from parent	☐ Unable to care for hygiene/nutrition/basic needs
☐ Lies/Blames others for own misbehavior	☐ Unusual behaviors dressing, bathing, mealtime, or counting rituals	☐ Nervous tics or other repetitive, abrupt nervous movements or vocal noises
☐ Cruel to animals	☐ Picky eater	☐ Grief/Loss
☐ Violates curfew/Has run away	☐ Self-injury/Cutting/Burning	☐ LGBTQ concerns
☐ Suspected alcohol/drug use	☐ Suicidal thoughts/threats/actions	☐ Friendship/Relationship problems
☐ School suspensions/Alternative school	☐ Witness to domestic violence	Other:
☐ Inappropriate sexual activity	☐ History of physical abuse	
☐ History of unwanted sexual contact	☐ History of sexual abuse	

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name_____Sex_____Age_____DOB_____
2. Natural Child Yes / No If adopted, at what age_____ Foster since _____
3. Parent's Names (include step-parents, foster parents, inc.)

_____

_____

4. Comments about custody and visitation (if applicable):

_____

_____

5. Primary reason you are concerned about your child?

_____

_____

_____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a.
_____ Sleep problems
_____ Lack of interest in activities
_____ Unassertive
_____ Fatigue/low energy
_____ Concentration problems
_____ Appetite/weight changes
_____ Withdrawal

b.
_____ Forgetful/memory problems
_____ Short attention span
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers

_____ Morbid thoughts
_____ Suicidal thoughts or threats
_____ Suicidal plans / attempts
_____ Mood swings
_____ Depression
_____ Changed level of activity
_____ Cries easily

_____ Talks excessively / interrupts
_____ Easily distracted
_____ Irritable
_____ Impulsive
_____ Difficulty following rules
_____ Problem completing schoolwork

c.
_____ Excessive worry / fearfulness
_____ Anxiety or panic attacks
_____ Social fears, shyness
_____ Separation problems
_____ Bedwetting / soiling
_____ Headaches, stomachaches
_____ Odd beliefs / fantasizing
_____
_____ Nightmares
_____ Frequent tantrums
_____ Resistive to change
_____ School refusal
_____ Perfectionism
_____ Odd hand / motor movements
_____ Hallucinations
_____

d.
_____ Lying
_____ Trouble with the law
_____ Running away
_____ Truancy, skipping school
_____ Hurting others sexually
_____ Alcohol / drug use
_____ Argumentative / defiant
_____ Swears
_____ Blames others for mistakes
_____ Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if has no fear
_____ Short tempered
_____ Easily annoyed / annoys others
_____ Discipline problem
_____ Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School: _____ Grade: ____ Teacher: _____
2. Has child ever repeated any grade? _____
3. Is child in special education services? No ____ Yes, what kind? _____
4. Please describe academic or other problems your child has had in school

_____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____
Full-term _____ Premature _____ if premature, number of weeks _____

Birth Weight: _____

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

_____

2. **Developmental History**

- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively? _____ Rarely cried _____

3. **Health History of Child**

In the first two years, did your child experience: ___Separation from mother, ___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
- Dental problems? Yes ____ No ____
- Any head injuries or loss of consciousness? Yes _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No _____ Yes – describe and give dates _____

- Is your child currently taking any medications? No ____ Yes ____ name medications

_____

- List any medicines previously used for emotional problems: were they helpful? ____

  _____

- Allergies to drugs or medicines? No ____ Yes ____ (list) _____
- Allergies to any foods? No ____ Yes ____(list) _____
- Are there any foods that you limit or do not give this child? No ____ Yes ____

  (list) _____.
- Allergies to environmental conditions? No ____ Yes ____(list) _____
- Does anyone in the household smoke? No ____ Yes ____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No ____ Yes ____

  National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No ____ Yes ____

  If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No _____ Yes _____

  Whom/where _____when_____
- Any previous testing (school/psychological)? No _____ Yes _____

  Whom/where _____when_____
- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

  Comments: _____

Family History:

Chemical use (now & past): No _____ Yes _____ Which parent _____

Type: Alcohol _____ Marijuana _____ Other drugs_____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

Has child witnessed domestic violence? __Y, __N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

4. Other stressors or traumas? _____

_____

What are your child's strengths?

AXIOS BEHAVIORAL HEALTH
FINANCIAL AND PAYMENT POLICIES

Our policy is full payment at the time services are rendered. We accept Cash, Check, Visa, Discover, and Master Card. There will be a $75 service charge for each returned check.

We require a **24 Hour notice for cancellation.** We will attempt to make a reminder call or text the business day before your appointment as a courtesy, however you are responsible for keeping up with all appointments.
_____ For *late* cancellations you will be charged $50 _____ For *No Shows* you will be charged $50
(Initials) (Initials)

You may leave a voicemail on our line or call during business hours for all prescription refill request or appointment change/cancellation request.

Your insurance card(s) may be copied each time you are seen. We must verify correct insurance information at each visit. We will gladly file your primary and secondary insurance for you.

Benefits quoted by your insurance company are **NOT** a guarantee of payment. You will be asked to pay any charges not paid by your insurance company.

We bill your insurance as a courtesy. If you disagree with any amount your insurance pays or they do not pay, you are responsible for the terms of that agreement.

Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement. You are responsible for confirming with your insurance company that the providers you are seeing are in your network.

You may be billed for letters or forms completed by your provider. Fees vary. (Require 10 business days)

It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for additional attorney or collection fees. If you are covered by managed care you may be exempt from payment of charges not fully covered by your insurance.

I authorize ABH to file insurance for me and to provide the insurance company any information necessary. I further authorize payment to be made directly to my provider at ABH.

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered. I agree to be liable for any costs incurred in the collection of any unpaid balance, including all reasonable attorney fees.

I authorize my provider at ABH to release any medical and/or psychiatric information acquired in the course of my examination or treatment to my health insurance company to facilitate payment for medical services rendered. I authorize payment of medical benefits to my provider at ABH.

Initial _____ **Date** _____

AXIOS BEHAVIORAL HEALTH
EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about abuse, neglect, or exploitation of a minor
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

AXIOS BEHAVIORAL HEALTH INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I can discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Initial _____ **Date** _____

AXIOS BEHAVIORAL HEALTH

PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by **AXIOS BEHAVIORAL HEALTH** (hereinafter referred to as "**ABH**") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of BH.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. ABH is not required to agree to the restrictions that I may request. However, if ABH agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ABH has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ABH 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of ABH. The Notice of Privacy Practices also describes my rights and ABH 's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

ABH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

Initial _____ **Date** _____

TELEHEALTH CONSENT FORM

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to assist in the evaluation, diagnosis, management and treatment of their patients.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional and unintentional corruption

By signing this form, I understand the following:

1. The consulting healthcare provider/ specialist will be at a different location than me.
2. I hereby authorize Axios Behavioral Health to use the telehealth practice platform of telecommunication for evaluating, testing and diagnosing my medical condition(s).
3. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment can not be started or finished as intended.
4. I accept that the professionals can conduct interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed and internet connection cannot be met.
5. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
6. I understand that although I may have not spoken with my healthcare provider for the full time that was billed (either to my insurance or myself) that the additional time was used to complete any medical charting and sending needed medications to my pharmacy.
7. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation but still be kept private and confidential.

I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my healthcare.

Patient Signature: _____ Date: _____

AXIOS BEHAVIORAL HEALTH

CONTROLLED SUBSTANCES AGREEMENT FORM

Patient Name _____ **Date**_____

The purpose of this agreement is to prevent any misunderstandings regarding controlled substances that you may be prescribed by the providers at this clinic. The goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. This agreement is also set forth to assist you and your provider to comply with the law regarding controlled pharmaceuticals.

Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following polices are agreed to by you, the patient, to help maintain safety and provide quality, effective care.

I agree to the following (please initial on each line to affirm agreement):

___ I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's medication.

___ I will not increase my medication until I speak with my provider. If I do so on my own, the provider may taper and d/c medication. Use of medication at a greater rate than prescribed may result in my being without medication for a period of time.

___ My medication may not be replaced if it is lost, stolen or consumed earlier than prescribed. My prescription for a controlled substance may not be replaced if lost/stolen.

___ Renewals are contingent on keeping scheduled appointments. I will not phone/text for prescriptions after hours or on weekends. Early refills will not be given.

___ I will exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery.

___ I will not obtain any controlled medications, including benzodiazepines, controlled stimulants or anti-anxiety medications to treat the same symptoms from any other doctor. **I understand the use of recreational or designer medication and alcohol is completely prohibited while taking controlled medication.**

___ You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

Pharmacy Name: _____
Address: _____

___ I understand that I must completely one in-office visit every three months to continue to be prescribed controlled medication.

I understand that if I break this Agreement, my provider may stop prescribing me certain medications and/or release me from the clinic. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding this agreement have been adequately answered.

Patient Signature _____ Witness _____