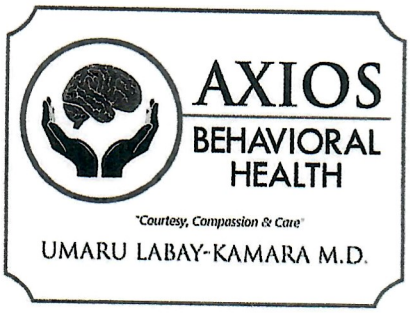

101 East Charles Street
Suite 202
La Plata, MD 20646
Phone Number: (301) 934-3415
Fax Number: (301) 934-3417

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:**_____

What concern(s) bring you to our clinic?

_____

_____

What has been causing your stress as of late? (Family, job, recent loss, financial issues)

_____

_____

Are you currently having any of the following issues? (Circle all that apply)

Depression Low mood for >2 weeks Excessive sleeping Loss of Interest Guilt/ Worthlessness Low Energy Trouble Concentrating Poor Appetite/ Overeating Weight Loss/ Weight Gain Psychomotor Slowing Thoughts/ Plans of Suicide	**Mania** ("Giddiness") Grandiose Increased activity Decreased judgment Distractible Irritability Need less sleep Elevated mood Speedy talking Speedy thoughts	**Psychosis** Hallucinations/illusions Delusions Self-reference: -people watching you -people talking about you -messages from the media Thought blocking/insertion Disorganization: -speech -behavior	**Panic Attacks** Trembling Palpitations Nausea Chills Choking/Chest pain Sweating Fear: -dying -going crazy Anticipatory anxiety Avoidance Agoraphobia
Generalized Anxiety Excessive worrying Restless/ Edgy Easily Fatigued Muscle tension Difficulty sleeping Difficulty falling asleep Difficulty concentrating	**Social Phobia** Performance situations: -fear of embarrassment -fear of humiliation -criticism **Specific Phobias** Heights Crowds Animals	**Antisocial Personality** Forensic history: -arrests/imprisonment Aggressiveness/Violence Lack of empathy/remorse Lack of concern for safety: -self or others Childhood conduct disorder	**PTSD** Experienced/witness event Persistent re-experiencing Dreams/ Flashbacks Avoidance behavior Hyper-arousal: -Increased vigilance -Easily startled
Body Dysmorphia Excess concern with appearance or certain body parts Avoidance behavior **Eating Disorders** Binging/ Purging/ Restriction/ Amenorrhea Perception of body image or weight	**Borderline Personality Disorder** Fear of abandonment/ rejection Unstable relationships Chronic emptiness Low self esteem Intense anger/outbursts Self-damaging behavior Impulsivity	**Obsessive-Compulsive Disorder** Intrusive thoughts Persistent thoughts Excessive thoughts/ fears/ behaviors Irrational thoughts/ fears/ behaviors Repetitive behaviors: -washing/ cleaning -counting/checking -organizing/ praying	**ADHD/ ADD** Inattentiveness at work Hyperactivity Excessive fidgeting Poor time management Disorganization Forgetfulness Impulsiveness Lack of motivation Age symptoms started:___

Past Psychiatric Care

Have you ever been diagnosed with a mental health condition by a medical provider (e.g., Depression, Bipolar Disorder, Schizophrenia, ADHD)

_____

_____

Have you ever been seen by a psychiatrist, therapist, or counselor?

Provider	Date(s)	Reason seen	Treatment received

Have you ever been hospitalized for psychiatric care?

Facility	Reason for admission	Date(s)	Treatment received

Past Medications

Have you ever been treated with any of the following medications? Please circle all that apply and specify if you had a positive or negative reaction.

Medication	Reaction	Medication	Reaction	Medication	Reaction
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	
Campral		Luvox		Suboxone	
Celexa		Marplan		Symmetrel	
Chloralhydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topamax	
Concerta		Norpramin		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Please list any other medication you have been prescribed that were not listed below

---

Please list all medication you are currently taking including over-the-counter medications, herbal supplements, and any other supplements.

Medications	Dosage/ Milligram	Frequency	Reason taking	Prescriber

Past Medical Care

Do you have a primary care doctor? YES/NO

Facility Name: _____ Provider's Name: _____ Last seen: _____

What medical illnesses do you have?

_____

What surgeries have you had in the past?

_____

Please list all your allergies and their reactions below (e.g., medication, food)

Allergy	Reaction

Substance Use History

Substance	Last used	How often in a week, month or year do you use?	How much do you use/consume in one sitting?	When do you use? (e.g., at night, socially)
Tobacco				
Alcohol				
Cocaine				
Marijuana				
Opiates				
Heroin				
Xanax				
Ativan				
Klonopin				
Valium				
Mushrooms				
Other:				
Other:				
Other:				
Other:				
Other:				
Other:				

Family History

Please list all direct blood relatives who have been diagnosed with the following:

Alcoholism	
Anxiety	
Bipolar disorder	
Cancer	
Depression	
Diabetes	
Drug abuse	
Heart disease	
Hypertension	
Arrhythmias	
Osteoporosis	
Seizures	
Schizophrenia	
Stroke(s)	
Suicide	
Thyroid disease	

Social History

Who lives in the home with you? _____

What is your highest level of education? _____

What is your current job/ occupation? _____

What jobs have you had in the past? _____

Are you married? YES/NO If yes, for how long? _____

Have you been married in the past? YES/NO If yes, how many times? _____

Have you had any legal issues? (arrests, charges, time in jail)? If so, please explain:

_____

_____

Have you ever been the victim of a violent crime? YES/NO

If yes, please explain:

_____

_____

Have you ever been a victim of physical abuse, emotional abuse, sexual abuse, or rape? YES/NO

If yes, please explain if you feel comfortable:

_____

_____

Safety

Do you currently have thoughts of hurting yourself? YES/NO

If yes, please explain: _____

Have you tried to hurt yourself in the past? YES/NO

If yes, please explain: _____

_____

Do you currently have thoughts of hurting someone else? YES/NO

If yes, please explain: _____

Have you tried hurting anyone in the past? YES/NO

If yes, please explain: _____

_____

Do you or anyone in your home own guns or knives? YES/NO

If yes, please explain: _____

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

CONSTITUTIONAL:
Yes No
☐ ☐ Weight Loss
☐ ☐ Fatigue
☐ ☐ Fever

EYES:
Yes No
☐ ☐ Glasses/Contacts
☐ ☐ Eye Pain
☐ ☐ Double Vision
☐ ☐ Cataracts

EAR,NOSE,THROAT:
Yes No
☐ ☐ Difficulty Hearing
☐ ☐ Ringing in Ears
☐ ☐ Vertigo
☐ ☐ Sinus Trouble
☐ ☐ Nasal Stuffiness
☐ ☐ Frequent Sore Throat

CARDIOVASCULAR:
Yes No
☐ ☐ Murmur
☐ ☐ Chest Pain
☐ ☐ Palpitations
☐ ☐ Dizziness
☐ ☐ Fainting Spells
☐ ☐ Shortness of Breath
☐ ☐ Difficulty lying Flat
☐ ☐ Swelling Ankles

ENDOCRINE:
Yes No
☐ ☐ Loss of Hair
☐ ☐ Heat/Cold Intolerance

RESPIRATORY:
Yes No
☐ ☐ Cough Easy
☐ ☐ Coughing Blood
☐ ☐ Wheezing
☐ ☐ Chills

GASTROINTESTINAL:
Yes No
☐ ☐ Heartburn/Reflux
☐ ☐ Nausea/Vomiting
☐ ☐ Constipation
☐ ☐ Change in BMs
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Abdominal Pain
☐ ☐ Black or Bloody BM

GENITOURINARY:
Yes No
☐ ☐ Burning/Frequency
☐ ☐ Nighttime
☐ ☐ Blood in Urine
☐ ☐ Erectile Dysfunction
☐ ☐ Abnormal Discharge
☐ ☐ Bladder Leakage

ALLERGIC/IMMUNOLOGIC:
Yes No
☐ ☐ Hives/Eczema
☐ ☐ Hay Fever

PSYCHIATRIC:
Yes No
☐ ☐ Anxiety/Depression
☐ ☐ Mood Swings
☐ ☐ Difficult Sleeping

HEMATOLOGY/LYMPH:
Yes No
☐ ☐ Easy Bruising
☐ ☐ Gums Bleed Easily
☐ ☐ Enlarged Glands

MUSCULOSKELETAL:
Yes No
☐ ☐ Joint Pain/Swelling
☐ ☐ Stiffness
☐ ☐ Muscle Pain
☐ ☐ Back Pain

SKIN:
Yes No
☐ ☐ Rash/Sores
☐ ☐ Lesions
☐ ☐ Itching/Burning

NEUROLOGICAL:
Yes No
☐ ☐ Loss of Strength
☐ ☐ Numbness
☐ ☐ Headaches
☐ ☐ Tremors
☐ ☐ Memory Loss

FEMALES ONLY:
Date Last Mammogram_____
Normal____ Abnormal_____
Date last PAP_____
Normal____ Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular?
Yes____ No____
Number
Pregnancies_____

http://compliance.med.ufl.edu/compliance-tips/review-of-systems-ros-in-em-services/

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" 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	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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 _____