Jerad M. Dalton, DO / Ann Kledzik, MD / Michele Thorne, PhD, HSPP
Child, Adolescent, and Adult
Psychotherapy and Medication Management

Dear Patient,

Thank you for contacting Axon Health Associates. We look forward to meeting you and discussing your questions and concerns. We recommend that you arrive fifteen minutes prior to your first scheduled appointment time so check in can be completed prior to the doctor meeting with you.

Please complete this patient information packet prior to your visit.

We recommend that you bring any pertinent records or information for review. This may include prior evaluations, developmental/psychological testing, and prior medication records.

Please be prepared to pay for your appointment at the time of service. We are happy to file with your insurance company if you would like us to do so, and they may reimburse you for a portion of the visit depending on your coverage.

If you cannot keep this appointment, please call the office as soon as possible.

Thank you,

Jerad Dalton, DO
Ann M. Kledzik, MD
Michele Thorne, PhD, HSPP

9245 North Meridian Street, Suite 225 Indianapolis, Indiana 46260
Phone (317)818-9000, Fax (317)818-9009

Registration Form

PATIENT INFORMATION

Patient's Name: _____ Birth Date: _____
(Last) (First) (Middle Initial)

Home Address: _____
(Street / Box #) (City/State) (Zip)

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Marital Status: _____ Male _____ Female _____

Primary Physician: _____ Phone: _____

Primary Physician Address: _____

Source of Referral: _____

PARENT/GUARDIAN/EMERGENCY CONTACT INFORMATION

Mother's Name: _____ Home Phone: _____

Address (if different from patient's): _____
(Street / Box #) (City/State) (Zip)

Mother's Employer: _____ Mother's Occupation: _____

Mother's Work Phone: _____ Mother's Cell Phone: _____

Father's Name: _____ Home Phone: _____

Address (if different from patient's): _____
(Street / Box #) (City/State) (Zip)

Father's Employer: _____ Father's Occupation: _____

Father's Work Phone: _____ Father's Cell Phone: _____

INSURANCE INFORMATION

Primary Ins. Co. Name: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____

Relationship to patient: _____ EDI / Payer ID: _____

Policy Holder's ID#: _____ Group #: _____

Claims Address: _____

Dr. Jerad Dalton, DO / Dr. Ann Kledzik, MD / Dr. Michele Thorne, PhD, HSPP

9245 N. Meridian St. Suite 225
Indianapolis, IN 46260
(317) 818-9000 (Tel)
(317) 818-9009 (Fax)

Patient History Questionnaire

Name_____ Birth Date_____
Person Completing Questionnaire/Relationship to Patient_____

Purpose of Evaluation

What are your primary questions and concerns?

Past Medical History

	Yes	No	Comments
Have you ever been diagnosed with a medical condition? Please list:			
Have you ever been hospitalized? If so, when and for what condition?			
Have you ever had surgery? If so, what for?			
Are you currently taking any medications? If so, please list medication and dosage.			

Current Medical Concerns

	Yes	No	Comments
Do you have any allergies to medications?			
Do you have any sleep concerns? If so, please describe.			
Do you have any concerns with energy level? If so, please describe.			
Do you experience headaches? If so, with what frequency?			
Do you experience stomach pain? If so, with what frequency?			

Past Mental Health Treatment

Please list any previous medications that you have been prescribed for mood, anxiety, or attention and any side effects you experienced.

_____
_____
_____

Have you ever received counseling or psychotherapy? If so, when and what was the name of the therapist?

_____
_____
_____

Educational History

Please circle your highest level of education achieved:

Some High School
High School Diploma
Some College
Associate's Degree
Bachelor's Degree
Additional Post-secondary Education

Family History

Please list the persons presently living in your home.

Name	Sex	Birth Date	Relation to patient

During the past 12 months has your family experienced any of the following:

	Yes	No	Comments
Death of a Family Member			
Serious Illness			
Marital Problems			
Unemployment			
Other(please describe)			

Have any family members experienced any of the following?

	Yes	No	Comments
Depression			
Anxiety			
ADHD			
Autism			
Bipolar disorder			
Schizophrenia			
Other mental health diagnoses			
Heart or blood pressure problems (if yes, please describe)			
Other medical problems (if yes, please describe)			

Person Completing this Form: _____

Relation to Patient: _____

CONSENT TO TREAT

I hereby authorize Axon Health Associates, LLC and its respective personnel to provide evaluation and treatment to _____. If I am unable to attend the appointment as a guardian, I hereby authorize the following people to attend the appointment in my place:

_____

I understand that these services are not guaranteed as to results, that no guarantees have been provided by Axon Health Associates, LLC, and that there are certain risks involved with these services. I understand that I can terminate this consent for treatment by requesting termination in writing.

_____ _____

Patient/Legal Guardian Signature Date signed

_____

Relationship to patient

PRIVACY ACKNOWLEDGEMENT

I understand that the patient's health information is private and confidential. I understand that with this consent, I give permission for aspects of my/my child's private healthcare information to be shared with Axon Health Associates, LLC, as is necessary for services to be provided. I understand that Axon Health Associates, LLC may use and disclose the patient's personal health information to help provide care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. By law, Axon Health Associates, LLC must report actual or suspected child or elder abuse to the appropriate authorities. In addition, Axon Health Associates, LLC is legally bound to take appropriate action if my child or I threaten anyone with violence, harm, or dangerous actions. I understand that there is a detailed document titled "Notice of Privacy Practices" that contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this acknowledgement. I am aware that a copy of this notice will be given to me upon my request or that it may be found at axonhealth.org. Axon Health Associates, LLC has established procedures which help meet patient obligations. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs, etc. I will assist Axon Health Associates, LLC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices". My signature below indicates that I have been given the chance to review a current copy of the "Notice of Privacy Practices".

_____ _____

Patient/Legal Guardian Signature Date signed

_____

Relationship to patient

FINANCIAL AGREEMENT

I agree to pay in full, at the time of service, for all services rendered for myself or my child by Axon Health Associates, LLC, for any out-of-network services. I understand that there is a document available upon request or at axonhealth.org regarding the Fee Schedule and any financial obligations, and I have read and agree with the information in this document. For in-network services, I agree to pay for my co-pay at the time of service and understand that my insurance company will be billed for the remainder. I am aware that there is a document titled Insurance Tips that is available upon request or at axonhealth.org. This document will be helpful to understand what portion of the fees may be covered by my insurance plan. I understand that 24 hours notice of cancellation is required to avoid charges for missed appointments. I understand that in families where parents do not share the same household, payment for services is the responsibility of the parent who accompanies the child to the appointment.

I also understand and agree to pay for any services related to legal matters, including but not limited to depositions, attorney phone calls, and court testimony; these services may be a different pay rate.
I also understand and agree to pay for services including record retrieval, phone consultation, and email consultation as requested by the provider.

_____ _____
Patient/Legal Guardian Signature Date signed

_____
Relationship to patient

CONSENT TO USE EMAIL COMMUNICATIONS

I hereby agree to sending to and receiving from Axon Health Associates, LLC email communications as part of comprehensive treatment for my child. I understand the risks of sending PHI through email even with encryption, and with this agreement I am accepting these risks to my child's PHI. I accept that Axon Health Associates, LLC shall not be held responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Axon Health Associates, LLC if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing in writing. With my signature, I believe that the benefits of using email communications for my child's healthcare outweigh the security risks.

_____ _____
Patient/Legal Guardian Signature Date signed

_____
Relationship to patient

Preferred email address: _____