Dear Parents/Guardians,

Thank you for contacting Axon Health Associates and expressing interest in the DBT Adolescent Skills Training Group! We look forward to the possibility of working with you and your family. Our goal for this group is to help equip your family to effectively face life's challenges and enhance your hope for the future.

We would appreciate it if you would please take the time to complete this client information packet prior to your assessment appointment. Please plan to arrive 10 minutes prior to your scheduled time. You may bring any additional records or information that may be relevant for the group leaders to know. For acceptance into the group, youth must be involved in concurrent individual therapy. We can best serve your family by coordinating our efforts with your youth's primary therapist.

Please be prepared to pay for the assessment appointment at the time of service. A fee schedule is included and outlines the financial details for the group sessions. More information regarding the group will be provided during the initial appointment. Axon will be happy to file with your insurance company, if you would like, and you may be reimbursed for a portion of the cost on an out-of-network basis.

If you are unable to keep your appointment, please call the office as soon as you are able to and we will be happy to reschedule. However, please note the assessment must be completed prior to the start date of the group in order to be eligible.

Thank you and we look forward to meeting you soon!

Gratefully,

Carrie Kinder, LCSW Manda Collins, LCSW

REGISTRATION FORM

DBT Adolescent Skills Training Group

CLIENT INFORMATION

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

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

Employed? ___Y ___N If so, where? _____

Primary Physician: _____ Phone: _____

Primary Physician Address: _____

Who referred you to this group? _____ Phone: _____

PARENT/GUARDIAN & EMERGENCY CONTACT INFORMATION

Parent/Guardian Name: _____ Relationship: _____

Phone # (indicate type):_____

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

Employer: _____ Occupation: _____

Parent/Guardian Name: _____ Relationship: _____

Phone # (indicate type):_____

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

Employer: _____ Occupation: _____

Other Emergency Contact Name: _____

Relationship: _____ Phone: _____

DBT Adolescent Skills Training Group

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

Client History Questionnaire

Youth's Name_____ Birth Date_____

Name of Person Completing _____ Relationship to Client_____

Purpose of Evaluation

What prompted you to express interest in this group?

Past Mental Health Treatment

Current Individual Therapist _____ Phone_____

Please list any current medications youth has been prescribed relating to mood/attention.

_____

_____

Please give details of any past treatment received (including acute, hospitalization, IOP, outpatient individual/family therapy, day treatment, other groups, etc.)

FACILITY/AGENCY	LEVEL OF CARE	DATES	MD/THERAPIST	DIAGNOSIS/OUTCOMES

Educational History

Current School: _____ Grade Level: _____

Please list any difficulties youth is having in regards to school: _____

_____
_____

Please describe any educational services or resources that are provided to youth (IEP, 504 plan, special education services, etc.)

_____
_____

Please describe any extracurricular activities in which youth participates.

_____
_____

Please describe youth's peer group and how she interacts with others.

_____
_____

Family History

Parents are:

		Date
Married	____	_____
Separated	____	_____
Divorced	____	_____
		If divorced, please describe custody arrangement and parenting time_____
Unmarried	____	_____
Widowed	____	_____

Please list the persons presently living in your home.

Name	Sex	Age	Relation to Youth	Highest Grade Completed

Important family members/support system who do not live in the home with youth.

Name	Sex	Age	Relation to Youth	Highest Grade Completed

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? If so, please note how this person is related to the youth.

	Yes	No	Impact on Life/Comments
Depression			
Anxiety			
ADHD			
Autism Spectrum			
Bipolar disorder			
Schizophrenia			
Substance abuse/Alcoholism			
Intellectual Disability			
Other mental health diagnoses			
Other medical problems (if yes, please describe)			

Thank you for taking the time to complete this!

FEE SCHEDULE

Initial Assessment Appointment—50-60 min		$100
Module	**# of Weeks**	**Fee**
Orientation & Mindfulness	3	$195
Distress Tolerance	4	$260
Emotion Regulation	6	$390
Interpersonal Effectiveness	7	$455
Full 20 weeks with 10% off	20	$1170

Each client will require an initial assessment appointment to determine eligibility for the group. After the assessment appointment, a notification will be sent regarding acceptance or denial. Payment for the full module is due prior to the start of the module. You can decide to either commit to each module along the way or to the full 20 weeks. For maximum benefit and the most effective results, full participation and completion of the group is strongly encouraged. For those who commit to all 20 weeks with full payment at the start of group, a 10% discount will be given. (This savings is equivalent to 2 weeks of group.) Group members may not complete partial modules and the group will be closed to new members at times.

Please note changes may occur and we will do our best to notify you as soon as possible of any changes.

_____ _____

Signature of Guardian Name of Youth

_____

Date

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.

_____ _____
Client/Legal Guardian Signature Date signed

_____
Relationship to Client

PRIVACY ACKNOWLEDGEMENT

I understand that the client'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 client's personal health information to help provide care to the client, 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 called the "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. Axon Health Associates, LLC has established procedures which help meet client 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".

_____ _____
Client/Legal Guardian Signature Date signed

_____
Relationship to Client

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. 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 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.

_____ _____
Client/Legal Guardian Signature Date signed

_____
Relationship to Client

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.

_____ _____
Client/Legal Guardian Signature Date signed

_____
Relationship to Client

Preferred email address: _____

Child, Adolescent, and Adult
Psychotherapy and Medication Management

Authorization for Exchange of Information

Name: _____Date of Birth: ____/____/____

Address: _____SS#:____/____/____

I hereby authorize Axon Health Associates, LLC
[ ] to release [ ] to obtain

Records to/from:

_____
Name Company

_____
Address Phone# Fax#

I request the following information to be released regarding myself and/or my child:
[ ] Initial Assessment and Treatment Plan [ ] Progress Notes
[ ] Psychological Evaluation [ ] Psychiatric Evaluation
[ ] Diagnosis [ ] Discharge Summary [ ] Other: [ ] Verbal [ ] Written

Indicate specific information to be EXCLUDED from this authorization (check all that apply):
[ ]Drug and Alcohol Records [ ] HIV/AIDS Records [ ] Infectious Disease records

The purpose for use or disclosure of information:
[ ] Continuity of Care [ ] Coordination of Services
[ ] Other: please provide a specific description of the purpose /use for disclosure:
_____

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and cannot be released or re-released without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time, except to the extent that release has already occurred. This consent is valid for 90 days from the date signed by the patient or authorized party below, unless revoked by me prior to that date, upon the completion or satisfaction of the event or conditions specified; whichever comes first. A copy of this authorization shall be valid as the original.

I understand that the following fees may apply:
Record Retrieval $25.00
Charge $.25 (per page over 10 pages)
1-2 Day Service $10.00

Patient/Guardian Signature: _____Date:_____

_____ _____
Patient/Guardian Printed Name Witness Signature

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