ASHEBORO
BEHAVIORAL MEDICINE
727 S. Fayetteville St., Ste C
Asheboro, NC 27203
336-625-2073 336-625-2737 (FAX)

Child and Adolescent Intake and Assessment

Name: **Date:**

Who referred you?
What is the reason you are seeing a therapist?

ALL OF THE FOLLOWING QUESTIONS ARE ABOUT THE PERSON WHO IS SEEKING TREATMENT

SYMPTOM CHECKLIST

check all that apply	
___ cry easily	___ anxiety/constant worrying
___ irritable	___ phobias
___ depressed or sad	___ times when heart races or can't breathe and feel will die
___ withdrawn	___ frequently having repetitive thoughts
___ feel tired/no energy	___ need to have everything in an exact order
___ appetite/weight change	___ engage in repetitive behaviors
___ loss of interest in doing things	___ difficulty making and keeping friends
___ problems paying attention	___ problems starting projects
___ problems controlling impulsive behavior (ex. Interrupting others, can't wait turn)	___ do things to get rid of weight (throwing up, using diuretics, excessive exercise)
____ can't sit still	___ frequently angry
___ lies	____ hits other children
__ periods don't need sleep AND not tired	____ runs away from home
__ periods of increased energy	_____ steals
___ frequently masturbates/is sexually active or engages in sexually inappropriate touching of others	____ has been suspended from school
___ hearing voices, seeing things others don't see	___ hurts animals
___ thoughts of seriously harming someone	__ have been physically abused
____ currently has thoughts of harming themselves or yourself	__ have been sexually abused

If you have seen a therapist please list the name and address of the provider:
If you have seen a psychiatrist please provide the psychiatrist name and address:
Has the child ever been in a psychiatric unit? ___ **YES** ___ **NO**
Dates and Hospitals :

CURRENT MEDICATIONS

Name	Dose	Prescribed By	Reason for taking it

Please list all known allergies:

Substance Use

Please fill in for all the substances you use

	Daily	A Week	Weekly	Rarely	Never	In Past
Alcohol						
Marijuana						
Cocaine/Crack						
Speed/LSD/Crystal Meth						
Intravenous (IV) Drugs						
Heroin						
Ecstasy						
Inhalants						
Tobacco						

FAMILY PSYCHIATRIC HISTORY

Please Check All That Apply

	SIBLINGS	FATHER	MOTHER	MOTHER'S RELATIVES	FATHER'S RELATIVES
Aggression/Defiance					
Attention/ ADHD					
Impulse Control					
Bipolar Disorder					
Depression					
Anxiety					
Schizophrenia					
Motor or Vocal Ticks					
Rituals (ex. hand washing)					
Obsessions					
Learning disabilities					
Thyroid problems					
Drug abuse					
Antisocial behavior (stealing etc.)					
Huntington's Disease					
Dementia					
Self harm/Suicide					
Other:					

Child/Adolescent's Medical History

Please list all known allergies:

What is the date of last physical?

Please list any medications or substances that the mother took during pregnancy:

How many months into the pregnancy was the child birth?

Were there any complications during the pregnancy or child birth?

If was in NICU, how long _____
Reason:

Circle any of the following that apply

Anorexia at birth	Forceps used during birth	Eating problems as an infant	Poor eye contact
Delayed in crawling	Delayed in walking	Delayed in talking	Problems with potty training
Head banging	Hard to comfort	Stutters	Doesn't adjust to change
Ear infections	Ear tubes	As an infant hard to comfort	Seizures
Hearing problems	Visions problems	Problems w/ motor skills	

Have you ever experienced a head injury? ___**YES** ___ **NO** If yes, describe location of injury, how it occurred, and any medical exams.

Have you ever experienced loss of consciousness? ___ **YES** ___ **NO**

List any current medical problems and the physician who is treating them:

Family Assessment

Siblings:

Name	Age	Gender	Full/Step/Adopted	Where do they live

Who does the child/adolescent currently live with?

If they are living in more than one home, please list everyone they live with in the second home.

Are parents? _____married, _____never married _____separated _____divorced ___ other__

Are you (parents) experiencing marital conflict? _____YES _____NO

If separated or divorced how old was child/teen when you separated/divorced?_____

Who has custody?_____

How often is visitation?_____

If child does not have contact with other parent, How old where they when this happened? _____

Reason other parent doesn't have contact_____

Is the father remarried?_____

Is the mother remarried?_____

Are there any things I need to know about the child's home/family?

How many good friends does your child/adolescent have?

Child/Adolescent Education and Legal Assessment
What is the name of the school you attend?
What grade are you in?
Have you ever been left behind a grade?
What is your favorite subject in school? Least favorite subject?
What are your current grades?
What grades did you make this time last year?
Do you have an IEP? **___YES ___NO** Have you ever been tested at school for a learning disability? **___YES ___NO** If yes, when?
Is your child/adolescent having behavioral problems at school? **___ YES ___ NO** Explain
Any legal concerns? **___YES ___NO** If yes, what?

_____ _____

Parent/Legal Guardian's Signature Date

Patient Information Sheet

Asheboro Behavioral Medicine

DATE COMPLETED _____

Patient Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Hm:_____ Wk:_____ Cell:_____ Sex: M ☐ F ☐

Date of Birth: _____ Marital Status: _____ Soc. Sec. #: _____

Employer: _____ ☐ Full-Time ☐ Part-Time

RESPONSIBLE PARTY Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home: _____ Phone Number: Hm:_____
Wk:_____ Cell:_____

Employer: _____ ☐ Full-Time ☐ Part-Time

Relationship to Patient: _____

PRIMARY CARE PHYSICIAN: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (___)_____

EMERGENCY CONTACT Name: _____
(Parent or Guardian for Minors)

Phone No: Home: _____ Work: _____

REFERRED BY: _____

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BILLING AUTHORIZATION

I understand that if I do not provide the correct and updated insurance information I will be billed for the session. I also understand that Asheboro Behavioral Medicine has the right to terminate services for non-payment.

_____ _____

Signature Date

I agree to have Asheboro Behavioral Medicine submit claims to insurance agencies on my behalf. I understand that I am responsible for payment of services and claims not covered by my insurance.

_____ _____

Signature Date

I DO NOT agree to have Asheboro Behavioral Medicine submit claims to insurance agencies on my behalf. I understand that I am responsible for payment for all services and failure to do so gives Asheboro Behavioral Medicine the right to terminate services.

_____ _____

Signature Date

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SERVICE CONTRACT FOR OUTPATIENT THERAPY

Welcome to the practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our session. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES – What You Can Expect

Therapy cannot be described in general terms it must fit each person and their specific problems. Together you and your therapist will develop a treatment plan that best fits your needs and alter it as needed. This can only be done if you openly express your concerns during treatment. There are many different methods your therapist may use to deal with the problems that you hope to address. Therapy is an active process and for it work you must work on any assignments that are given to you between sessions, think about what is discussed in session, and come to session ready to discuss material.

Therapy can have benefits and risks. Since therapy may involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and loneliness. It is your right to tell your therapist if it becomes too uncomfortable and ask them to go at a slower pace. Other times you and the therapist will decide to develop a therapy plan which is more focused on developing new skills and solutions. Again this depends on your needs. Therapy often leads to better relationships, solutions to specific problems, learning new skills for handling emotions and crisis, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. You have the right to withdraw from therapy at any point in time but we ask that you notify your therapist of your decision.

The first few sessions will involve an evaluation of your needs and a development of a therapy plan which you and the therapist will develop together. You and your therapist will decide if therapy is the right course of treatment for you. You are an active participant in your treatment please ask questions and inform your therapist of you thoughts and concerns. Although your therapist may have some experience with medication, they have not been to medical school and do not prescribe medication. Your therapist does however, with consent; work closely with your physician to meet all of your needs.

MEETINGS

Therapy sessions last 53 plus minutes. How frequently they are scheduled depends on the treatment plan that you and your therapist develop, your specific needs, your insurance, and finances.

PROFESSIONAL FEES/ BILLING AND PAYMENTS

- You are responsible for payment of all sessions and for knowledge of your health insurance benefits. We are happy to assist you with this process. If you choose to use health insurance you must sign a release so that we can release required information to your billing company. While health insurance companies usually only ask for basic information and are also bound by confidentiality, Asheboro Behavioral Medicine is not responsible for the protection of your information when the insurance company possesses it.

- All copays are due prior to the beginning of the therapy session. In order to avoid your running up large amounts of debts we maintain the right to reschedule your session if you do not have your copay at the time of service

- In order to meet your scheduling needs we must be able to have available appointments. Since an appointment takes an entire hour, when you cancel late or do not show then someone else goes without a needed appointment. Therefore if you do not cancel by 8am the day before your appointment, you may be charged a fee of $50. Please note that this will not be covered by your health insurance.

- If you cancel late or do not show for two or more appointments, than it is at the discretion of the therapist to terminate you as a patient from Asheboro Behavioral Medicine. Late cancellations and frequent No Showing have been shown to signal a lack of commitment to therapy. You will be notified of this by phone or by a letter depending on the circumstances. If this is something that you foresee as a problem, it is your responsibility to discuss it with your therapist.

- In order to spend time better addressing your needs the therapist attempts to conduct therapy in the office and keep paperwork to a minimum. Therefore, if a telephone call takes over 15 minutes (a billable session) they reserve the right to charge you for a session at their discretion. Again please note that this is not covered by insurance. Likewise you may be billed for paperwork which is time intensive like writing summary letters, writing letters for disability, filling out complex forms, and asked to cover the costs of copying your records, each form completed outside of therapy shall be billed at a rate of $25 per form and must be paid in advance. Medicaid does not pay for time filling out paperwork for disability therefore **NO FORMS FOR MEDICAID CLIENTS WILL BE DONE OUTSIDE OF YOUR THERAPY APPOINTMENT. THIS INCLUDES REQUESTS FOR PATIENTS RECORD RELEASES FOR ATTORNYS, DSS OR THE SOCIAL SECURITY ADMINISTRATION.**

CONTACTING YOUR THERAPIST

Your therapist will often not be immediately available by telephone. The best way to reach them during business hours is by calling our main number 625-2073 during hours and leaving a message, they will return your call as soon as possible. Questions regarding your medications can not be addressed by your therapist rather you should call the physician who prescribed your medications.

If it is afterhours an emergency call 911. If it is after hours and you need to speak to someone please call 625-2073 and then press 1, your call will be routed to the emergency afterhour's voice mail. Please clearly state your name and telephone number and the nature of the call. You should be contacted within one hour by the on call provider. Please stay by your phone and unblock it so you can receive calls without caller ID.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____	_____
Client's Signature	Date
_____	_____
Legal Guardian's Signature	Date
_____	_____
Therapist	Date

Asheboro Behavioral Medicine, PLLC
727 South Fayetteville Street
Asheboro, NC 27203

AUTHORIZATION FOR TWO WAY RELEASE OF PROTECTED INFORMATION

This form is a two way consent form and when completed and signed by me or my legal representative I understand that it authorizes the release of my protected health information to and from the person or entity I delegate below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal or state privacy regulations.

PATIENT: _____ DOB: _____

I, hereby authorize Asheboro Behavioral Medicine, PLLC to release my behavioral health records including if relevant records pertaining to substance abuse/treatment/HIV diagnosis (42 CFR §§2.11 and 2.13. A Part 2) to:

NAME _____

(Of Organization, MD, or School you Are Giving Permission to Release Information To)

ONLY LIST ONE PERSON PER FORM

And I AUTHORIZE: _____

(WRITE SAME NAME AS YOU WROTE ON LINE ABOVE)

to release information to Asheboro Behavioral Medicine, PLLC
Indicate any limitations or exclusions to this consent: _____

The purpose of this disclosure is: Provide Continuity of Care: Other: _____

I understand that unless earlier revoked, this authorization will expire one year from the date that I sign this.

I understand that I have the right to revoke this authorization at any time by given written notification to Asheboro Behavioral Medicine, PLLC. However, the revocation will not be effective to the extant that action has been taken in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim. Asheboro Behavioral Medicine, PLLC and its employees or independent practitioners, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below I indicate that I have read all of the above and understand and agree.

_____ _____
(Patient/Legal Representative) Relationship to Patient

_____ _____
(Date) Witness

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PLEASE USE A SEPARATE CONSENT FORM FOR EACH AGENCY

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EMERGENCY CONTACT & APPOINTMENT REMINDERS

We are currently trying to remind people of their appointments. There are also times that we may need to reach you for other reasons or to reschedule an appointment due to an unforeseen emergency or illness. It is helpful if we have all of your current contact information so that we can provide better service to you. Please let us know if anything changes. Thank you.

Patient's Name_____ DOB:_____

Parent/Guardian's Name (If patient is a minor) _____

HOME PHONE_____Is it Ok to leave a msg? _____Yes _____No

WORK PHONE_____Is it Ok to leave a msg? _____Yes _____No

CELL PHONE_____Is it Ok to leave a msg? _____Yes _____No

Which Number is best to reach you at during the day?

Home Work Cell

Which number is best to reach you at night? (after what hour usually?_____

Home Work Cell

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HIPPA CONSENT FORM

FOR THE SECURITY AND DISCLOSURE OF PROTECTED HEALTH

INFORMATION TO OUR PATIENTS:

Patient information will be maintained by Asheboro Behavioral Medicine as described by the *Notice of Privacy Practices* available upon request by asking Asheboro Behavioral Medicine, PLLC in compliance with federal and state regulations.

Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone that you may elect in writing to receive it. We will release information related to a work related injury to your employer.

We reserve the right to:

- Call you to remind you of your next appointment and leave information on your answering machine or voice mail.

I have read and understand my rights:

_____ _____

Client or Legal Guardian's Signature Date

_____

Witness

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LIMITS OF CONFIDENTIALITY

PATIENT'S COPY

In general, the privacy of all communications between a patient and a psychologist/therapist is protected by law, and we can only release information about our work to others with your written permission. No one outside of Asheboro Behavioral Medicine can have access to the information in your file without your consent except under the following circumstances:

1. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

2. There are some situations in which we are legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we are required to file a report with the appropriate state agency.

3. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

4. Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your therapist for medical emergency situations and in general for continuity of care.

5. We reserve the right to dictate notes and letters. The person that does the transcription is trained in the laws governing Confidentiality and cannot reveal anything contained in the transcripts

6. For purposes of covering call information is shared with Asheboro Counseling who is governed by the same statutes governing Confidential Information.

7. We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

8. If you choose to use health insurance, you must sign a release so that we can release required information to your billing company. While health insurance companies are also bound by confidentiality, Asheboro Behavioral Medicine is not responsible for the protection of your information when the insurance company possesses it.

9. When working with adolescents and children we keep all information discussed in session confidential unless we feel that the child or teen is engaging in a practice that will put them at risk. As a parent or guardian, you are agreeing by your signature below, that you waive all rights under law to the contents of your child/ren's charts and notes.

10. In the course of couples/family therapy, occasions arise where one or the other participant may have an individual therapist. Asheboro Behavioral Medicine reserves the right to release to the individual's therapist that information which may benefit that individual with the consent of that one party.

If these situations occur, we will make every effort to fully discuss it with you before taking any action. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client's Signature	Date
Legal Guardian's Signature	Date
Therapist Asheboro Behavioral Medicine	Date