HALLOWELL
BOSTON METROWEST

144 North Road, Suite 2450, Sudbury, MA 01776
p: 978-287-0810 | f: 978-287-5566

PATIENT REGISTRATION - CHILD

Today's Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: (Primary/Cell) _____

(Home)_____ (Work)_____

Email address: _____

Sex (check one): ☐ *M* ☐ *F* Date of Birth: _____ Age: _____

Relationship Status (check one): ☐ *Single* ☐ *Partnered* ☐ *Married* ☐ *Divorced* ☐ *Widowed*

Employment (check one): ☐ *Full Time* ☐ *Part Time* ☐ *Unemployed*

Student (check one): ☐ *Full Time* ☐ *Part Time* ☐ *Unenrolled*

Responsible Party *(person billing statements will be sent to)*:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Number: _____

How did you hear about The Hallowell Center? _____

Would you like to receive our monthly *Newsletter* by email? ☐ Yes ☐ No

Health Insurance Portability and Accountability Act (HIPAA)
By signing the document, I am acknowledging that I was given the HIPAA Patient's Service Agreement with regards to the use and disclosure of my personal information. I acknowledge that I am in-agreement with The Hallowell Center's policies.

Signature: _____

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HALLOWELL CENTER PATIENT SERVICES AGREEMENT

The Hallowell Center promotes a setting of trust, confidentiality, and respect. We protect patient privacy, maintain the legal requirements of confidentiality, and work to prevent the misuse of patients' information. The Hallowell Center implements and maintains policies and procedures in compliance with the Health Insurance Portability and Accountability Act (HIPAA) a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that The Hallowell Center provide you with a notice of Privacy Practices regarding our use and disclosure of your PHI for treatment, payment, and health care operations. The law requires that The Hallowell Center obtain your signature acknowledging that we have provided you with this information. Thank you in advance for reading this information regarding your privacy.

LIMITS ON CONFIDENTIALITY

With Authorization or Consent

The law protects the privacy of all communication between a patient and the patient's clinicians. In most situations, The Hallowell Center can release information about your evaluation and treatment to others ***only if you sign a written authorization*** that meets certain legal requirements imposed by HIPAA.

However, there are some situations that require only that you provide ***advance written consent***. Please note that your signature on this agreement provides consent for the following:

- Consultation about your evaluation/treatment between clinicians at The Hallowell Center;
- Consultation about your evaluation/treatment with clinicians outside the Center;
- Management of your records and information by administrative staff at Center.

Please note that all clinicians in and outside the Center are legally bound to keep information confidential, and that staff at the Center are contractually bound to protect your privacy and maintain confidentiality.

Without Authorization or Consent

There are some comparatively rare situations where The Hallowell Center is permitted or required to disclose information without either your authorization or consent. These are as follows:

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- The patient is clearly a danger to him/herself or others;
- An incident is disclosed regarding the neglect or abuse of a child, a mentally or physically disabled person, or an elderly person;
- The Hallowell Center receives a court order requesting information regarding a patient;
- The patient files for Worker's Compensation, in which case The Hallowell Center must, upon appropriate request, provide appropriate information, including a copy of the patient's record, to the patient's employer, the insurer, or the Department of Worker' s Compensation.

If such a situation arises, we will make every effort to fully discuss the situation with you before taking any action. We will strive to limit our disclosure only to what is strictly necessary.

Minors and Parents
By law, the parents of patients who are under eighteen (18) years old and not emancipated are allowed to examine their child's treatment records and hold the rights regarding release of information.

Please note that in divorce situations, both parents have equal access to their child's records, even if one parent has sole legal custody.

PROFESSIONAL RECORDS

In your patient record at The Hallowell Center we keep particular information about you. The record may have your diagnosis, reason for seeking treatment, goals set for treatment, your progress toward those goals, your medical/family/social history, treatment history, and past treatment records. Your record may also contain billing forms, and authorization from you allowing specific people to have access to your record (i.e. other care providers, or insurance providers).

If you request it in writing, you may examine and/or receive a copy of your record, except in the very rare case where we believe that access to it would endanger you. In this situation you have the right to a summary of your record, and to have your record sent to another mental health provider or to your attorney.

PATIENT RIGHTS

HIPAA provides you with rights regarding your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of disclosure of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; recording in your records any complaints you make about policies and procedures; and the right to a paper copy of this Agreement. We are happy to discuss with you any of these rights.

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INSURANCE INFORMATION

The Hallowell Center does not contract with any insurance companies or plans, including Medicare. Our services are provided on a private pay basis only. Payment is due at the time of service.

You are free to submit claims to your insurance company for services you receive at The Hallowell Center. You should be aware that insurance companies often require a clinical diagnosis, treatment plan, treatment summary, or even copies of the patient's entire record. We will only provide information to your insurance company if you sign a release form specifying who is to receive the information, the type of information to be released, the purpose for which the information is being requested, and for what period of time the authorization is valid.

_____

My signature below indicates that I have read The Hallowell Center Patient Services Agreement and agree to its terms, according to the Health Insurance Portability and Accountability Act (HIPAA).

Your Signature: _____

Your Relationship to Patient (check one):

☐ *Self* ☐ *Parent* ☐ *Legal Guardian* ☐ *Other*

Today's Date: _____ **Patient's Date of Birth**: _____

Patient's Name (print):_____

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INSURANCE WAIVER

The Hallowell Center does not contract with any insurance companies or plans, including Medicare. Our services are provided on a private pay basis only. Payment is due at the time of service.

You are free to submit claims to your insurance company for services you receive at The Hallowell Center. However, please be aware that we do not become involved in this process. Further, please be aware that your insurance company may not reimburse you for our services.

If you have any questions about this policy, a member of our staff will be happy to speak with you.

Please sign below to indicate that you understand and accept our reimbursement policies.

I have read the Insurance Waiver. By signing, I am indicating that I understand and accept the reimbursement policies of The Hallowell Center.

Name (print): _____

Signature: _____

Today's Date: _____

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HALLOWELL CENTER POLICIES ON REPORT WRITING, LEGAL TESTIMONY, and SUBPOENAS

REPORT WRITING and LEGAL TESTIMONY

At times clients may request that their clinician write a letter or report to a third party (such as a school, employer, insurance company, or disability services provider). Occasionally a client may request that his or her clinician offer legal expert witness testimony. In such situations, the clinician will first discuss with the client whether or not such action is in the client's best interest. If the client and clinician agree that it is in the client's best interest to proceed, and after the client provides written consent, the clinician will write the letter or report, or offer legal testimony. The Hallowell Center reserves the right to charge the clinical rate per hour for writing or testimony; fees are due and payable at the time of service.

SUBPOENAS

In the event that a formal legal subpoena for records or testimony is received by The Hallowell Center, the client will be notified in writing, and provided with a copy of the subpoena. The client must either provide his or her clinician with a waiver of objection to the subpoena, in writing, *OR* the client must inform the clinician that an objection will be filed with the court by the client's attorney. If an objection to the subpoena is to be filed with the court, it is the client's responsibility to have the objection filed, and a copy of the objection must be given to the clinician.

All services and expenses incurred by the clinician(s) and The Hallowell Center for court-related issues will be charged to the client, and subject to our regular payment policies. Specifically, any time required for contacts with attorneys, depositions, or courtroom proceedings will be charged at the clinical rate per hour.

_____

I have read The Hallowell Center policies on Report Writing, Legal Testimony, and Subpoenas. I understand and agree to abide by them.

Your Signature: _____

Your Relationship to Patient (check one):

☐ *Self* ☐ *Parent* ☐ *Legal Guardian* ☐ *Other*

Today's Date: _____ **Patient's Date of Birth**: _____

Patient's Name (print): _____

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HALLOWELL CENTER PAYMENT POLICY

Services at The Hallowell Center are provided on a private-pay basis only. We do not contract with or send bills to any insurance companies, including Medicare. Please read the following, in order to further clarify our payment policy. Please let us know if you have any questions or concerns.

1. Payment is due on the day of your visit

2. We accept cash, checks, Master Card, Visa, American Express, or Discover.

3. We require twenty-four (24) hour notice of cancellation. If you cancel an appointment within less than twenty-four hours of the scheduled time, or if you miss an appointment without notice to our office staff, you will be charged for that appointment. Monday appointments must be cancelled by 4p.m. on Friday afternoon.

4. We may require payment for the following additional services:
    a. Telephone Consultation: billed at fifteen (15) minute increments at our usual clinical rates.
    b. Completion of Forms: disability forms, insurance reports, letters, and other forms of written communication are billed in fifteen-minute increments at our usual clinical rates.
    c. Legal Consultation: report writing, correspondence, and telephone contact for legal actions are billed at $200 per hour for all clinicians. Payment in full is requested prior to releasing prepared letters and reports in legal matters.

5. You may request one copy of your medical records for yourself in accordance with the Health Insurance Portability and Accountability Act (HIPAA), to be provided at no charge. All subsequent copies of record reproduction will cost $60 per copy.

By signing below, I indicate that I have read The Hallowell Center Payment Policy and agree to its terms.

Your Signature: _____

Your Relationship to Patient (check one):

☐ *Self* ☐ *Parent* ☐ *Legal Guardian* ☐ *Other*

Today's Date: _____ **Patient's Date of Birth**: _____

Patient's Name (print):_____

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DEVELOPMENTAL AND HEALTH HISTORY – CHILD

Patient Name: _____

Date of Birth: _____ **Today's Date:** _____

Form completed by (check one**)**:

☐ *Mother* ☐ *Father* ☐ *Grandparent* ☐ *Legal Guardian* ☐ *Other*

PREGNANCY and DELIVERY

Length of pregnancy by weeks _____

Length of delivery by hours _____

Mother's age when child was born _____

Child's birth weight _____

Did any of the following conditions occur during pregnancy? **Check *NO* or *YES***

1.	Bleeding	☐ *N* ☐ *Y*
2.	Weight gain of more than 30 lbs.	☐ *N* ☐ *Y*
3.	Toxemia / Preeclampsia	☐ *N* ☐ *Y*
4.	Rh factor incompatibility	☐ *N* ☐ *Y*
5.	Frequent nausea or vomiting	☐ *N* ☐ *Y*
6.	Serious illness or injury	☐ *N* ☐ *Y*
7.	Took prescription medication (name: _____)	☐ *N* ☐ *Y*
8.	Took illegal drugs	☐ *N* ☐ *Y*
9.	Used alcohol (approximate number of drinks per week: _____)	☐ *N* ☐ *Y*
10.	Smoked cigarettes (approximate number of cigarettes per day: _____)	☐ *N* ☐ *Y*
11.	Used marijuana (approximate amount per week: _____)	☐ *N* ☐ *Y*

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Did any of the following occur during delivery? **Check *NO* or *YES***

1.	Delivery was induced	☐ *N* ☐ *Y*
2.	Forceps were used during delivery	☐ *N* ☐ *Y*
3.	Had a breech delivery	☐ *N* ☐ *Y*
4.	Had a cesarean section delivery	☐ *N* ☐ *Y*
5.	Injured during delivery	☐ *N* ☐ *Y*
6.	Cardiopulmonary distress during delivery	☐ *N* ☐ *Y*
7.	Delivered With cord around neck	☐ *N* ☐ *Y*
8.	Had trouble breathing during delivery	☐ *N* ☐ *Y*
9.	Needed oxygen	☐ *N* ☐ *Y*
10.	Was cyanotic, turned blue	☐ *N* ☐ *Y*

Did any of the following occur within the first few days after birth? Check *NO* or *YES*

1.	Was jaundiced, turned yellow	☐ *N* ☐ *Y*
2.	Had an infection	☐ *N* ☐ *Y*
3.	Had seizures	☐ *N* ☐ *Y*
4.	Was given medications	☐ *N* ☐ *Y*
5.	Was born with a congenital defect	☐ *N* ☐ *Y*
6.	Was in the hospital for more than seven days (number: ____)	☐ *N* ☐ *Y*

HEALTH AND TEMPERAMENT

During the first twelve (12) months, was your child: **Check *NO* or *YES***

1.	Difficult to feed	☐ *N* ☐ *Y*
2.	Difficult to get to sleep	☐ *N* ☐ *Y*
3.	Colicky	☐ *N* ☐ *Y*
4.	Difficult to put on a schedule	☐ *N* ☐ *Y*
5.	Alert	☐ *N* ☐ *Y*

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During the first twelve (12) months, was your child: **Check *NO* or *YES***

6.	Cheerful	☐ *N* ☐ *Y*
7.	Affectionate	☐ *N* ☐ *Y*
8.	Sociable	☐ *N* ☐ *Y*
9.	Easy to comfort	☐ *N* ☐ *Y*
10.	Difficult to keep busy	☐ *N* ☐ *Y*
11.	Overactive, in constant motion	☐ *N* ☐ *Y*
12.	Very stubborn, challenging	☐ *N* ☐ *Y*

EARLY DEVELOPMENTAL MILESTONES

At what age did your child first accomplish the following:

1.	Sitting without help	_____
2.	Crawling	_____
3.	Walking alone, without assistance	_____
4.	Using single words (e.g. "mama," "dada," "ball," etc.)	_____
5.	Putting two words together (e.g. "mama up")	_____
6.	Bowel training, day and night	_____
7.	Bladder training, day and night	_____

HEALTH HISTORY

Date of the child's last physical exam: _____

At any time, has your child had the following? **Check *NEVER*, *PAST*, or *CURRENT***

1.	Asthma	☐ *N* ☐ *P* ☐ *C*
2.	Allergies	☐ *N* ☐ *P* ☐ *C*
3.	Diabetes, arthritis, or other chronic illness	☐ *N* ☐ *P* ☐ *C*
4.	Epilepsy or seizure disorder	☐ *N* ☐ *P* ☐ *C*
5.	Febrile seizures	☐ *N* ☐ *P* ☐ *C*
6.	Chicken pox or other common childhood illness	☐ *N* ☐ *P* ☐ *C*
7.	Heart or blood pressure problems	☐ *N* ☐ *P* ☐ *C*

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At any time, has your child had the following?		**Check *NEVER*, *PAST*, or *CURRENT***
8.	High fever over 103 degrees	☐ *N* ☐ *P* ☐ *C*
9.	Broken bones	☐ *N* ☐ *P* ☐ *C*
10.	Severe cuts requiring stitches	☐ *N* ☐ *P* ☐ *C*
11.	Head Injury	☐ *N* ☐ *P* ☐ *C*
12.	Concussion	☐ *N* ☐ *P* ☐ *C*
13.	Loss of consciousness	☐ *N* ☐ *P* ☐ *C*
14.	Lead poisoning	☐ *N* ☐ *P* ☐ *C*
15.	Surgery (what kind?)	☐ *N* ☐ *P* ☐ *C*
16.	Lengthy hospitalization	☐ *N* ☐ *P* ☐ *C*
17.	Speech or language problems	☐ *N* ☐ *P* ☐ *C*
18.	Chronic ear infections	☐ *N* ☐ *P* ☐ *C*
19.	Hearing difficulties	☐ *N* ☐ *P* ☐ *C*
20.	Eye or vision problems	☐ *N* ☐ *P* ☐ *C*
21.	Fine motor and/or handwriting problems	☐ *N* ☐ *P* ☐ *C*
22.	Gross motor difficulties, clumsiness	☐ *N* ☐ *P* ☐ *C*
23.	Appetite problems (overeating or under eating)	☐ *N* ☐ *P* ☐ *C*
24.	Sleep problems (falling asleep, staying asleep, getting awake)	☐ *N* ☐ *P* ☐ *C*
25.	Sleep walking and/or night terrors	☐ *N* ☐ *P* ☐ *C*
26.	Soiling problems	☐ *N* ☐ *P* ☐ *C*
27.	Wetting problems	☐ *N* ☐ *P* ☐ *C*

Please use the space below to indicate any other developmental/health events or concerns.