HALLOWELL
NEW YORK CITY

117 West 72nd St, 3rd Floor ~ New York, NY ~ 10023
p: 212.799.7777 f: 212.799.7772
e: info@hallowellcenter.org

NAME: _____ **AGE:** _____ **DOB:** _____

APPT DATE: _____ **Provider:** _____

Health History Questionnaire

Today's Date:

What prompted you to visit the Hallowell Center?

_____

_____

_____

Emotional & Cognitive Symptoms:

Check all symptoms you have had over the past year:

- ☐ Anger
- ☐ Anxiety
- ☐ Aggressive behavior
- ☐ Attention problems
- ☐ Compulsive behavior
- ☐ Concerns re. Substance Use
- ☐ Depression
- ☐ Disorganization
- ☐ Eating problems
- ☐ Excessive energy
- ☐ Fears and phobias
- ☐ Flashbacks
- ☐ Headache
- ☐ Impulsive behavior
- ☐ Irritability
- ☐ Learning problems
- ☐ Memory Loss
- ☐ Negativity
- ☐ Obsessive thinking
- ☐ Periods of feeling too low or high
- ☐ Poor judgment
- ☐ Procrastination
- ☐ Perfectionism
- ☐ Panic
- ☐ Seasonal mood changes
- ☐ Sleep Issues
- ☐ Social Isolation
- ☐ Social Anxiety
- ☐ Stress
- ☐ Suicidal Ideation or Self-Injurious Behaviors
- ☐ Variable Mood Swings
- ☐ Worry
- ☐ Other sdfsdf

Personal History:

What do you see as your primary strengths?

_____

_____

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Are you experiencing difficulties in any of the following areas? (Please check all that apply)

- ☐ Relationships
- ☐ Financial
- ☐ Personal Hygiene
- ☐ Legal
- ☐ Living Arrangements

What is your highest level of education? _____

Did you experience any difficulty in…?(check all that apply)

- ☐ Elementary school
- ☐ Middle school
- ☐ High School
- ☐ College
- ☐ Graduate/Professional School

What is your current occupation? _____

Do you experience any difficulties in your functioning regarding your current occupation?

- ☐ Yes
- ☐ No

Health Habits:

Do you exercise regularly? ☐ yes ☐ no

What type of exercise?

_____

_____

Do you get a regular check-up/physical? ☐ yes* ☐ no
*if yes, what was the approximate date of your last physical? _____

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Have you had lab-work done in the past year? ☐ yes ☐ no

Do you use any of the following?

	Yes	No	Detail & Frequency
Alcohol:	☐	☐	
Nicotine/Tobacco:	☐	☐	
Caffeine:	☐	☐	
Cannabis/Marijuana:	☐	☐	
Recreational drugs:	☐	☐	

How many hours of sleep do you get on average? _____

Please rate the quality of your sleep (please check).

☐ Very Poor ☐ Poor ☐ Neither Gc Nor Bad ☐ Good ☐ Very G

Do you own any firearms at home? ☐ Yes ☐ No

Medical History:

Primary Care Physician: _____
Contact number: _____

Please list all of your medical conditions you are currently being treated for.

_____

_____

Current Medications (medical and psychiatric):

Name of Medication	Dosage	Start Date

*** your pharmacy can usually provide a quick and easy print-out of this information*

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Have you ever been concerned about misuse of medication? ☐ Yes ☐ No

Do you take any vitamins or supplements? ☐ Yes* ☐ No

*If yes, please list:

_____

Please list any prior medical conditions that may have an impact on your diagnosis and treatment.

_____

_____

Have you had any of the following conditions? (Please check all that apply)

☐ Seizures

☐ Concussions

☐ Other Traumatic Brain Injury

☐ Cardiovascular Issues (High Blood Pressure, Stroke, Heart Attack, etc.)

☐ Neurological Conditions (i.e. tic disorder)

Psychiatric History:

Are you currently in any psychiatric or mental health treatment?

☐ Yes (if yes, please fill out next two questions).
☐ No

Current Provider Information

Name: _____

Phone number: _____

Please list any current or past psychiatric diagnoses.

_____

_____

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Please list any prior psychiatric care

Please list any prior psychotherapy/coaching (please include style/type if known)

Please list any prior psychiatric hospitalizations

Please list any prior substance use inpatient and or outpatient treatment

Family Status and History:

Who is currently in your household? Please check all that apply and list the number of each (i.e. write 2 if you have 2 children).

- ☐ Spouse/Partner
- ☐ Children*
- ☐ Parents
- ☐ Grandparents
- ☐ Cousins/Aunts/Uncles
- ☐ Roommates

*If you have children, please list their ages and whether they have any psychiatric/learning issues below.

Please check your current marital status. Single ☐ Dating ☐

Married ☐ Divorced/Separated ☐ Widowed ☐

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Please indicate which relatives, if any, Past or present, diagnosed or suspected
m*=*mother* *f*=*father* *s*=*sibling* *g*=*grandparent* *o*=*other

_____ Substance Abuse or Alcoholism	_____ Abuse	_____ Anxiety
_____ Attention Deficit	_____ Bipolar disorder	_____ Depression
_____ Psychosis	_____ Suicide	_____ Trauma
_____ Violence	_____ Obsessive Compulsive	_____ Gambling Disorder
_____ Seizure disorder	_____ Personality disorder	_____ Eating Disorders

Notes/Details:

_____

_____

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my health history. I will not hold my doctors or any members of their staff responsible for errors or omissions that I may have made in completing this form.

_____ _____
Signature Date

_____ _____
Reviewed Date

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Pharmacy Information

Name of Pharmacy: _____

Phone Number: _____

Address: _____

_____

Your email: _____

If your pharmacy does not accept e-prescribe; please give us another pharmacy option.

Name of Pharmacy: _____

Phone Number: _____

Address: _____

_____

Insurance Information

Insurance Type: _____

Insurance ID Number: _____

Policy Holder/Subscriber Name: _____

Phone Number for Insurance Company: _____

We are now e-prescribing (not all pharmacies are).

Same-day prescription fee is $25

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PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____
Date of Birth: _____
Gender: _____
Street Address: _____
City, State & ZIP: _____ **Preferred?**
Home Phone: _____ ☐
Mobile Phone: _____ ☐
Work Phone: _____ ☐
Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Mobile Phone: _____

INSURANCE AND BILLING CONTACT

Name: _____
Relationship: _____
Street Address: _____
City, State & ZIP: _____ **Preferred?**
Home Phone: _____ ☐
Mobile Phone: _____ ☐
Work Phone: _____ ☐
Email: _____
Signature: _____
(required if financial guarantor is an individual other than the patient)

REFERRAL & COORDINATION OF CARE

How did you learn about the Hallowell Center?

- ☐ Other Provider
- ☐ Internet
- ☐ Dr. Hallowell's Books/Lectures/Podcast
- ☐ School
- ☐ Friends/Family
- ☐ Other (fill in here)

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Patient Rights and Responsibilities: I acknowledge that I have been provided with a written copy of my rights and responsibilities as a patient and I understand them.

Patient Confidentiality: I acknowledge receipt of the Notice of Privacy Practices and am aware of how to ask questions and voice concerns. I understand that the Hallowell Center may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, or any other person or entity affiliated with or representing for purposes of administration, billing, or quality and risk management; any hospital, nursing home, other healthcare facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and other healthcare providers in order to initiate treatment.

Release of Information: If you would like a summary of our findings forwarded to your healthcare provider or another clinician, please fill out the attached authorization form.

Electronic Communication and Privacy (*please initial each box*):

Please be aware that email and texting is not a secure way to transmit personal health information and there are limitations in security when using electronic communication. By your continued use of email with your clinician and the Hallowell Center, you accept the inherent privacy risks of electronic communication. NOTE: It is highly recommended that you avoid using electronic communication to discuss sensitive clinical information and limit electronic communication to brief updates only.

Authorization for Payment (*please initial each box*):

I understand that the Hallowell Center does not contract with any private of public insurance providers, including Medicaid or Medicare. While the Hallowell Center will provide appropriate codes for services so that you can submit for reimbursement from your insurance company, we will not submit to insurance companies on your behalf. It is your responsibility to know what services your insurance company covers. **This includes whether or not your insurance company covers telemedicine or just in person therapy sessions.**

I am a private pay patient and I agree to pay for all services rendered by the Hallowell Center.

I am aware that I will be charged at the clinician's hourly rate for letter and report writing, collaborative consultations, and any other services that exceed 15 minutes unless they are a routine part of scheduled care visits. Please check with your individual clinician about their policy regarding phone calls outside of scheduled sessions.

I have been informed of the cancellation policies for the Hallowell Center and understand that in the case of a last minute cancellation, I will be charged as listed below for my missed appointment. Please note that insurance does not cover late cancellations and no-shows. As a courtesy, our front desk staff confirms all appointments by phone and or email; however, not receiving a call or email doe not negate the cancellation policy.

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New client evaluations must be cancelled 48 hours in advance. For last minute cancellations or a no-show, you will be charged ½ of the new client evaluation price.

Regular appointments must be cancelled by 10:00am the previous business day before the scheduled appointment. Monday appointments must be cancelled by 10:00am the previous Friday. If Monday is a holiday and your appointment is on Tuesday, please cancel no later than 10:00am on the previous Saturday. For last minute cancellations or a no show, you may be charged the full fee.

Newsletter and Mailing List: The Hallowell Center would like to send you emails informing you of upcoming events and the center and other pertinent information to client's here, as well as the Hallowell Center newsletter. I acknowledge that by checking the box below I am opting out of receiving this service.

☐ **I want to opt out from receiving emails from the center regarding upcoming events, center updates, and the Hallowell newsletter.**

By signing this document, I am acknowledging that I am in agreement with the Hallowell Center policies.

Signature _____ Date _____

Reviewed by _____ Date _____

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Release of Information Authorization

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, Sate & ZIP: _____
Phone/Email: _____

I hereby authorize the Hallowell Center to (please check ALL that apply):

☐ Release records to self or legal guardian

*_**PLEASE NOTE:** based on HIPAA guidelines it can take 2-4 weeks to fully review and send your medical records for self-release._

☐ Release all information checked to the individual/party listed below

***information to be released:**

☐ Verbal Communication
☐ Email Communication
☐ Neuropsychology Reports
☐ Encounter Note(s)
☐ Rating Scales
☐ Summary Letter of Treatment
☐ Medication Information
☐ Other(please specify) _____

☐ Two-Way communication between the Hallowell Center and the individual/party listed below (e.g. parent, spouse, school, another provider, etc.).

Name: _____
Relationship: _____
Street Address: _____
City, Sate & ZIP: _____
Phone: _____

For the purpose of (please check one)

☐ Continued Treatment
☐ Legal Review
☐ Medication Refill Facilitation
☐ Other (please specify) _____
☐ Insurance purpose
☐ Personal review of information
☐ Scheduling Appointments

PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign this form in order to receive treatment
- I understand that I may revoke this authorization by providing a written statement to the Hallowell Center, except to the extent that it has already been completed.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the Hallowell Center from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of one year, and it automatically expires one year after the date this form is executed

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Signature	Date
Printed Name	Relationship to Patient

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CREDIT CARD AUTHORIZATION FORM

In order to facilitate timely continuation of treatment, we strongly encourage you to keep a credit card on file at our center. This card would be used for any account balances including but not limited to: therapy sessions, pharmacological follow-up appointments, coaching sessions,, late cancellations, or failure to arrive for an appointment without advance notice ("no-show appointments").

Name on credit card: _____

Patient's name (if different than above): _____

Email (for all invoices): _____

Card number: _____

Expiration date: _____

CVV (security code): _____

Billing Address: _____

_____

By signing this document, I am acknowledging that I am in agreement with the Hallowell Center policies below:

- Payment is due at the time of service, at the start of each session
- Account balances for services rendered at the Hallowell Center will be charged to the credit card that is obtained and held on file. If another form of payment is desired, it must be provided at the time of the scheduled appointment.
- If the credit card on file is lost, stolen, compromised, cancelled, or expired, the patient is responsible for informing the center and providing an additional form of payment.
- The Hallowell Center will never release credit card information under any circumstances.
- We will use the credit card on file to charge for late cancellations or no show appointments. **New client evaluations must be cancelled 48 hours in advance.** For last minute cancellations or a no-show, you will be charged ½ of the new client evaluation price. **Regular appointments must be cancelled by 10:00am the previous business day before the scheduled appointment. Monday appointments must be cancelled by 10:00am the previous Friday. If Monday is a holiday and your appointment is on Tuesday, please cancel no later than 10:00am on the previous Saturday.** For last minute cancellations or a no show, you may be charged the full fee.

_____ _____

Signature Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Hallowell Center NYC HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION. All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice, and to protect the privacy of your health information.

This "protected health information" includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) your Protected Health Information. With some exceptions, we may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of the notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the Protected Health Information already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy from the contact person listed at the end of this notice at any time and can view a copy of the notice on our website:

www.hallowellcenter.org/HIPAA.html

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below, we describe the different categories of when we use and release your Protected Health Information **without your consent**.

A. We may use, or disclose your protected health information for treatment, payment, or health care operations.

1. **For Treatment.** We may share your Protected Health Information among physicians, nurses, psychologists, social workers, interns, and other health care personnel who are directly involved in your health care at this clinic.
   For example: your primary therapist and your medication provider will share your protected health information to provide the best care for you. For external disclosures we will always ask for your authorization before we disclose your health information, except in emergencies to other mental health agencies or units.
2. **To obtain payment for treatment.** We may use and release your Protected Health Information in order to bill and collect payment **from you** for services provided to

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you. It is important that you provide us with correct and up-to-date information. **For example**, we may release portions of your Protected Health Information to our billing department to get paid for the health care services we provided to you.

3. **To run our health care business.** We may use your Protected Health Information internally, in order to operate our facility in compliance with healthcare regulations. **For example**, we may use your Protected Health Information to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. We DO NOT REQUIRE YOUR CONSENT to Use or Release Your Protected Health Information:

1. **When federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies request your Protected Health Information.** We release your Protected Health Information only when a law requires that we report information to government agencies or law enforcement personnel. Specifically we would notify the New York State Child Abuse Registry about victims of child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred; in missing person cases; or when ordered in a judicial or administrative proceeding.
2. **About Decedents.** We provide coroners/medical examiners at their request, necessary information relating to an individual's death.
3. **To avoid harm.** In order to avoid a serious threat to your safety or the safety of another individual, we may provide your Protected Health Information to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.
4. **For appointment reminders and health-related benefits and services.** We may use your demographic Protected Health Information to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.
5. **For health oversight activities.** We report information about serious incidents, including deaths, to the NY State Office of Mental Health and the Quality of Care Commission. We may use and disclose your Protected Health Information to a health oversight agency, including the NY State Office of Mental Health, Medicaid, Medicare, or your Health Insurance Plan, for oversight activities authorized by law, including audits, licensure, or other activities necessary for oversight of the health care system or disciplinary actions against our workforce.

C. Your Prior Written Authorization is required for any Uses and Disclosures of your Protected Health Information not included above.

1. **To obtain payment from your health care plan for treatment**. Pending your signed Consent for Release of information and Payment for Medical Benefits Form, we may use and release your Protected Health Information to your health plan in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date information.

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2. **Information shared with family, friends, or others.** We will only release your Protected Health Information to a family member, friend, or other person that you indicate is involved in your care if you agree to the disclosure by completing and signing an Authorization Form.
   We will ask for your written authorization before using or releasing any of your Protected Health Information. If you choose to sign an authorization to release your Protected Health Information, you may later cancel that authorization in writing. This will stop any future release of your Protected Health Information for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. **You Have the Right to Request Limits on How We Use and Release Your Protected Health Information.** If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit Protected Health Information that we are legally required or allowed to release.

B. **You Have the Right to Choose How We Communicate Protected Health Information to You.** All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

C. **You Have the Right to Request to See and Get Copies of Your Protected Health Information.** You must make the request in writing. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You may have the right to have the denial reviewed by a committee. You can request a summary or a copy of your Protected Health Information as long as you agree to the cost in advance. If your request to see your Health Information is approved, we will arrange this in accordance with established policy.

D. **You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your Protected Health Information.** This list **will not** include uses you have already authorized, or those for treatment, payment or operations. This list will not include disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list will include dates when your Protected Health Information was released and the purpose, with whom your Protected Health Information was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame.

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E. You have the Right to Correct or Update Your Protected Health Information. If you believe that there is a mistake in your Protected Health Information or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your Protected Health Information. If we approve your request, we will make the change to your Protected Health Information, tell you that we have done it, and tell others that need to know about the change or amendment to your Protected Health Information.

F. You have the Right to Receive This Privacy Notice. You have the right to request another paper copy of this notice at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your Protected Health Information, you may file a complaint with our Privacy Official listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

Our Clinical Coordinator: sue@hallowellcenter.org

EFFECTIVE DATE OF THIS NOTICE

This notice is in effect as of April 14, 2003.