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: _____

Gender Identity of Child: _____

Race and Ethnicity of Child: _____

Appointment Date: _____

Provider: _____

Developmental and Health History Questionnaire

Today's Date: _____

Name of Person Filling Out Form: _____

Relation to Child: _____

Reason for Assessment: Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

Please identify your child's strengths:

Please identify your child's challenges:

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

Family Composition:

Marital status of parents*: ☐ Single ☐ Married ☐ Divorced* ☐ Separated*
☐ Domestic Partnership ☐ Widowed

*If parents are separated or divorced, what is the child's current living situation?

☐ Living with mother full time ☐ Living with father full time
☐ Joint legal custody ☐ Other (please explain)

Mother's Name: _____ **Age:** _____

Occupation: _____ **Highest Level of Education:** _____

Father's Name: _____ **Age:** _____

Occupation: _____ **Highest Level of Education:** _____

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in-or outside the home. Please include all people currently residing in child's household.

Name	Gender	Age	Relationship to Client	Living with Child?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Is your child the gift of a reproductive donor or living adoption? ☐ **Yes** ☐ **No**

*If so, please provide any information on your child's biological parents when necessary in this new patient paperwork.

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

Current Behavior/Mental Health:

Do you feel this child exhibits any of the following behaviors more often than is typical for a child of his/her age? *(please select any that apply)*

- ☐ Touchy/easily annoyed
- ☐ Defies adult rules
- ☐ Angry/resentful
- ☐ Argues with adults
- ☐ Loses temper
- ☐ Blames others for mistakes
- ☐ Deliberately annoys
- ☐ Spiteful/vindictive
- ☐ Refuses to go to school
- ☐ Unusual fears
- ☐ Panic attacks
- ☐ Self-conscious/clingy
- ☐ Need for reassurance
- ☐ Somatic complaints
- ☐ Worry of future events
- ☐ Repeats certain actions
- ☐ Can't stop thinking about things
- ☐ Preoccupation with objects or ideas
- ☐ Rigidity
- ☐ Bullies/threatens
- ☐ Initiates physical fights
- ☐ Ever been arrested
- ☐ Physically cruel to others
- ☐ Cruel to animals
- ☐ Difficulty keeping friends
- ☐ Destroys property
- ☐ Deliberately sets fires Steals
- ☐ Has run away
- ☐ Extreme mood swings
- ☐ Does not show emotions
- ☐ Overreacts to sensory stimulation (light, music, touch)
- ☐ Strange or bizarre ideas
- ☐ Upset by change in routine
- ☐ Poor social interactions
- ☐ Self-injurious behavior
- ☐ Sexualized Behavior
- ☐ Excessive Use of Social Media or Video Gaming
- ☐ Irritable
- ☐ Changes in appetite
- ☐ Diminished interest Sleep problems
- ☐ Restlessness
- ☐ Fatigued/low energy
- ☐ Feels worthless
- ☐ Becomes tearful easily Indecisive/can't think
- ☐ Thinks about death
- ☐ Suicidal Ideation/Attempts
- ☐ Hurts self
- ☐ Currently uses drugs
- ☐ Used drugs in the past
- ☐ Currently drinks alcohol
- ☐ Used alcohol in the past
- ☐ Motor or vocal tics
- ☐ Trouble reading social cues

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

Family History:

Family History can often be helpful in understanding a child's challenges.

Has anyone in the family had (please check off any areas relevant):

	Siblings	Biological Parents	Grandparents	Adopted Parents	Others
Motor problems?	☐	☐	☐	☐	☐
Reading problems?	☐	☐	☐	☐	☐
Speech/language problems?	☐	☐	☐	☐	☐
School/learning problems?	☐	☐	☐	☐	☐
Alcohol/drug problems?	☐	☐	☐	☐	☐
Anxiety disorders?	☐	☐	☐	☐	☐
Mood disorders?	☐	☐	☐	☐	☐
Psychotic disorders?	☐	☐	☐	☐	☐
Seizures/Epilepsy?	☐	☐	☐	☐	☐
Attention problems/hyperactivity?	☐	☐	☐	☐	☐
Autism Spectrum Disorders?	☐	☐	☐	☐	☐
Trauma?	☐	☐	☐	☐	☐
Other history of mental illness?	☐	☐	☐	☐	☐

Is there anything else you think we should know about family history?

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

Birth History:

Were there any complications during pregnancy or delivery? ☐ YES ☐ NO

If yes, please elaborate:

Birth weight: _____ Full term? ☐ YES ☐ NO

If premature, how many weeks early? _____

During pregnancy with this child, did the birth mother:

Drink alcohol? ☐ YES ☐ NO
Take any recreational drugs/marijuana? ☐ YES ☐ NO
Smoke cigarettes? ☐ YES ☐ NO

If YES to any of the above, please elaborate:

What was the health of the child like at birth?

What was the health of the child like the first year of life?

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

Developmental History:

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help	☐	☐	☐	☐	☐	☐	☐	☐
Crawled	☐	☐	☐	☐	☐	☐	☐	☐
Walked alone	☐	☐	☐	☐	☐	☐	☐	☐
Spoke first words	☐	☐	☐	☐	☐	☐	☐	☐
Spoke short phrases	☐	☐	☐	☐	☐	☐	☐	☐
Spoke in sentences	☐	☐	☐	☐	☐	☐	☐	☐
Toilet trained	☐	☐	☐	☐	☐	☐	☐	☐
Stayed dry all night	☐	☐	☐	☐	☐	☐	☐	☐

During the first twelve months, was this child:

Easy to get to sleep?	☐ YES	☐ NO
Easy to put on a schedule?	☐ YES	☐ NO
Easy to comfort?	☐ YES	☐ NO
Overactive/in constant motion?	☐ YES	☐ NO
Easily irritated?	☐ YES	☐ NO
Alert?	☐ YES	☐ NO
Affectionate?	☐ YES	☐ NO
Make regular eye contact with caregivers?	☐ YES	☐ NO

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

As a young child, was your child….

Interested in other children?	☐ YES	☐ NO
Able to separate appropriately?	☐ YES	☐ NO
Able to play appropriately with toys?	☐ YES	☐ NO

Speech and Language:

Has his/her hearing ever been tested? ☐ YES ☐ NO

If yes, where & when: _____

What were the results? _____

Does this child have:

A history of frequent ear infections?	☐ YES	☐ NO
Tubes placed in his/her ears?	☐ YES	☐ NO
Any speech problems or difficulty speaking?	☐ YES	☐ NO
Trouble understanding what is being said?	☐ YES	☐ NO
Has (s)he ever worked with a Speech and Language therapist?	☐ YES	☐ NO

If yes, where & when: _____

What were the results? _____

Has (s)he ever had a Speech/Language Therapy? ☐ YES ☐ NO

If yes, where & when: _____

What frequency? _____

Motor Skills:

Does this child have:

Fine motor difficulties (writing, drawing)?	☐ YES	☐ NO
Has (s)he ever had an Occupational Therapy Eval?	☐ YES	☐ NO

If yes, where & when: _____

What were the results? _____

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

Has (s)he ever worked with an Occupational Therapist? ☐ YES ☐ NO

If yes, where & when: _____

What frequency? _____

Does this child have:

Gross motor difficulties (walking, running)? ☐ YES ☐ NO

Has (s)he ever had a Physical Therapy Evaluation? ☐ YES ☐ NO

If yes, where & when: _____

What were the results? _____

Has (s)he ever worked with a Physical Therapist? ☐ YES ☐ NO

If yes, where & when: _____

What frequency? _____

Does (s)he use any adaptive devices (braces)? ☐ YES ☐ NO

If yes, please describe: _____

Vision:

Has this child ever been to an eye doctor? ☐ YES ☐ NO

Most recent date: _____

Does this child wear glasses*? ☐ YES ☐ NO

If yes, why: _____

Has this child ever received vision treatment? ☐ YES ☐ NO

If yes, what type: _____

***Important: If a child wears glasses, please bring them to the appointment**

Medical History & Current Medical:

Pediatrician Name: _____

Pediatrician Phone Number: _____

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

Does your child have any diagnosable health issues? ☐ YES ☐ NO

If yes, please elaborate: _____

_____

Is (s)he currently taking any medications? ☐ YES ☐ NO

Name of Medication	Dose	Date Started	Reason

Did (s)he have any allergies? ☐ YES ☐ NO

If yes, please describe: _____

Did (s)he ever have a head injury or concussion? ☐ YES ☐ NO

Has (s)he ever had lead exposure or lead poisoning?

Does (s)he have a seizure disorder? ☐ YES ☐ NO

Has (s)he ever had a serious illness or hospitalization? ☐ YES ☐ NO

If yes, please describe: _____

Does (s)he see any medical specialists (neurologist, etc)? ☐ YES ☐ NO

Who & reason: _____

Who & reason: _____

Psychiatric History:

Has (s)he ever had a psychiatric evaluation? ☐ YES ☐ NO

If yes, where & when: _____

What were the results? _____

Has (s)he ever had neuropsychology/educational testing? ☐ YES ☐ NO

If yes, where & when: _____

What were the findings? _____

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

Has (s)he ever had any therapy? ☐ YES ☐ NO

If yes, where & when: _____

Type if known? _____

Has (s)he ever had any psychiatric hospitalizations, in-patient rehabilitation for eating disorders or substance abuse? ☐ YES ☐ NO

If yes, where & when: _____

For what? _____

Any history of physical or sexual abuse or trauma? ☐ YES ☐ NO

Has there been any significant life changes in the last 12 months (loss, moving, divorce, natural disaster, etc.)? ☐ YES ☐ NO

If yes, what type?: _____

School History:

Name of school/daycare: _____

Is this school…

Public? ☐

Private? ☐

Religiously Affiliated? ☐

Home-school? ☐

Gifted/Talented? ☐

Geared towards learning differences/social emotional issues? ☐

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

Has (s)he ever repeated a grade? ☐ YES ☐ NO

If yes, grade & reason: _____

Does (s)he have an IEP, 504, or school based accommodation/support? ☐ YES ☐ NO

Has (s)he ever received special/extra help in school? ☐ YES ☐ NO

If yes, please check the services received:

- ☐ Reading support
- ☐ Math support
- ☐ Counseling
- ☐ Foreign language waiver
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Gifted programs
- ☐ One on one aid
- ☐ Speech/language therapy
- ☐ Extra time
- ☐ Homework reduction
- ☐ Executive functioning tutoring/coaching

Has child every received executive functioning tutoring/coaching outside of school? ☐ YES ☐ NO

***IMPORTANT: PLEASE SEND MOST RECENT EVALUATION, REPORTS AND EDUCATIONAL PLAN (IEP) WITH THIS PACKET**

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my child's 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.

_____ _____
Parent/Guardian Signature Date

_____ _____
Reviewed by Date

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

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

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

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)

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

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 persona care facility of which I am a resident; any physician providing my care; family members and other caregiver 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 you clinician and the Hallowell Center, you accept the inherent privacy risks of electronic communication. NOTE is highly recommended that you avoid using electronic communication to discuss sensitive clinica 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.

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

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 o scheduled sessions.

I have been informed of the cancellation policies for the Hallowell Center and understand that in the case of 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.

- 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

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

CREDIT CARD AUTHORIZATION FORM

In order to facilitate timely continuation of treatment, you may be advised to keep credit card information 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, mailing of prescriptions, late cancellations, or failure to arrive for an appointment without advance notice ("no-show appointments"). ***Due to our 24-hour cancellation policy, we will charge the below credit card the morning of your appointment. Please contact us prior to the day of your appointment if you wish to use another form of payment. All New Patients must give a 48-hour cancellation notice, otherwise you will be charge $250 for a late cancellation or no show.***

Name on credit card: _____

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

Email (for all invoices): _____

Card number: _____

Expiration date: _____

CVV (security code): _____

Billing zip code: _____

Billing street number: _____

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

- 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, or cancelled, the patient is responsible for informing the center and providing an additional form of payment.
- The Hallowell Center will not release credit card information or charge for services not provided at the center without permission from the patient.
- Appointments must be cancelled 24-48 hours prior to the scheduled meeting time. Same day cancellations or a no-show appointment will result in billing at the full price of the appointment.

_____ _____

Signature Date

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

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 SFO & 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 anytime 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.

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

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 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.

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

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.
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. Please submit all requests for this information to:

PrivacyOfficer@hallowellcenter.org

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

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

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. Please submit all requests for this information to:

PrivacyOfficer@hallowellcenter.org

D. **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. Please submit all requests for this information to

PrivacyOfficer@hallowellcenter.org

E. **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 Privacy Official: PrivacyOfficer@hallowellcenter.org

EFFECTIVE DATE OF THIS NOTICE: This notice is in effect as of April 14, 2003.