familyhealth
ASSOCIATES

Today's Date: ____/____/_____

Patient Information Date of birth: ____/____/_____ Sex: Male Female Other

Last Name: _____ MI: ____ First Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____)_____ Cell Phone: (____)_____
Work Phone: (____)_____ Fax: (____)_____
E-mail Address: _____
Preferred form of contact: Home Phone Cell Phone Work Phone Email
Billing Address (if different from home address): _____
Marital Status: Single Married Divorced Widowed Separated Remarried

Parent Information (if patient is a child)
Parent #1 Date of birth: ____/____/_____ Sex: Male Female
Last Name: _____ MI: ____ First Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____)_____ Cell Phone: (____)_____
Work Phone: (____)_____ Fax: (____)_____
E-mail Address: _____
Preferred form of contact: Home Phone Cell Phone Work Phone Email
Billing Address (if different from home address): _____
Marital Status: Single Married Divorced Widowed Separated Remarried

Parent #2 Date of birth: ____/____/_____ Sex: Male Female
Last Name: _____ MI: ____ First Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____)_____ Cell Phone: (____)_____
Work Phone: (____)_____ Fax: (____)_____
E-mail Address: _____
Preferred form of contact: Home Phone Cell Phone Work Phone Email
Billing Address (if different from home address): _____
Marital Status: Single Married Divorced Widowed Separated Remarried

Emergency Contact
Contact Name: _____ Relationship to Patient: _____
Phone number: (____)_____

Referral Information

Referred by: _____ May we contact? Yes No

Phone number: (____)_____ E-mail: _____

Reason for referral: _____

_____

_____

Educational History

Elementary School: _____ Graduated in: _____ Did not graduate

High School: _____ Graduated in: _____ Did not graduate

College: _____ Graduated in: _____ Did not graduate

Graduate/Professional: _____ Graduated in: _____ Did not graduate

Other: _____ Graduated in: _____ Did not graduate

Occupational History

Self-Employed Not Employed

Current Position: _____ Current Employer: _____

Responsibilities: _____

Prior Position: _____ Prior Employer: _____

Primary Physician Information

Physician Name: _____ Phone Number: (____)_____

Address: _____

_____

Patient Medical Status

Height: ____ Feet ____ Inches Weight: _____ Lbs

Current Health Condition: Excellent Very Good Good Fair Poor

Please check the appropriate boxes if any of the following are applicable:

Yes No

Recent Hospitalization

Date: ____/____/_____ for ____ days

Reason: _____

Surgery

Date: ____/____/_____

Type: _____

Major Accident

Date: ____/____/_____

Type: _____

Past Surgeries Date

1. _____ ____/____/_____
2. _____ ____/____/_____
3. _____ ____/____/_____

Medication History

Past Medications Dose (if known) Dates of use (if known)

1. _____ _____ From ____/____/_____ to ____/____/_____
2. _____ _____ From ____/____/_____ to ____/____/_____
3. _____ _____ From ____/____/_____ to ____/____/_____
4. _____ _____ From ____/____/_____ to ____/____/_____
5. _____ _____ From ____/____/_____ to ____/____/_____

Current Medications

1. _____ _____ From ____/____/_____
2. _____ _____ From ____/____/_____
3. _____ _____ From ____/____/_____
4. _____ _____ From ____/____/_____
5. _____ _____ From ____/____/_____

Current Dietary Supplements/Vitamins/Herbal Supplements

1. _____ _____ From ____/____/_____
2. _____ _____ From ____/____/_____
3. _____ _____ From ____/____/_____

Diagnostic History

Has the patient ever been diagnosed with any of the following? Please check all that apply.

Comments

- Allergies _____
- Anxiety _____
- Attentional Problems _____
- Bipolar Disorder _____
- Cancer _____
- Compulsive Behavior _____
- Depression _____
- Diabetes _____
- Digestive Disorder _____
- Exposure to Lead _____
- Heart Problems _____
- Learning Disability _____
- Loss of Consciousness _____
- Manic Behavior _____
- Neurological Problems _____

Obsessive Behavior _____
Phobias _____
Seizures/Seizure Disorder _____
Sleeping Problems _____
Staring Into Space _____
Substance Use
Alcohol _____
Marijuana _____
Cocaine _____
Other _____
Suicidal Behavior _____
Thyroid Problem _____
Tic Disorder _____
Tourette's Syndrome _____
Other (please describe) _____

Treatment History

Is the patient currently in therapy, or has he/she ever been in therapy?

Date: ____/____/_____ to ____/____/_____
Name of Therapist: _____ May we contact? Yes No
Phone number: (____)_____ E-mail: _____

Has the patient ever had neuropsychological or other testing?

Date: ____/____/_____ Tested by: _____ May we contact? Yes No
Phone number: (____)_____ E-mail: _____

Please include below any additional pertinent information not listed above:

_____
_____
_____
_____
_____

Family Information

	Name	Age/Date of Birth	Occupation	Health Problems
Mother				
Father				
Siblings 1				
2				
3				
Children 1				
2				
3				

Please check any boxes applicable to family members.

Mother	Father	Sibling 1	Sibling 2	Sibling 3	Child 1	Child 2	Child 3	Condition	Comments
								Allergies	
								Anxiety	
								Attentional Problems	
								Bipolar Disorder	
								Cancer	
								Compulsive Behavior	
								Depression	
								Diabetes	
								Digestive Disorder	
								Exposure to Lead	
								Heart Problems	
								Learning Disability	
								Loss of Consciousness	
								Manic Behavior	
								Neurological Problems	
								Obsessive Behavior	
								Phobias	
								Seizures/Seizure Disorder	
								Sleeping Problems	
								Staring Into Space	
								Suicidal Behavior	
								Thyroid Problem	
								Tic Disorder	
								Tourette's Syndrome	
								Other (Please Explain)	

Name _____ Signature _____ Date ____/____/_____

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ASSOCIATES

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you or your child (as patients of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. Throughout this document the words "you" and "your" refer to you or your child as the patient of this practice.

PLEASE REVIEW THIS CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your **individually identifiable health information (IIHI).** In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. PRIVACY OFFICER

If you have any questions about this notice please contact:
Catherine Stern, Ph. D. 34 South Broadway, Ste. 702, White Plains, NY 10601

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice, including physicians, psychologists, and social workers may use your IIHI to treat you. For example, we may ask you to have laboratory tests to assist others in your treatment and we may use the results to help us reach a diagnosis. We may use you IIHI in order to write a prescription for you, or we may disclose your IIHI to a pharmacy when we order a prescription. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children, parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose you IIHI in order to bill and collect payment for the services you may receive from us.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. For example, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice.

4. **Appointment Reminder.** Our practice may use you IIHI to contact you and remind you of an appointment.

5. **Release of Information to Family and Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter or family member take his/her child to our office for treatment. In this situation, the person accompanying the child may have access to this child's medical information.

6. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. **USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique situations in which we may use or disclose your Individually Identifiable Health Information.

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

    - Maintaining vital records, such as births and deaths
    - Reporting child abuse of neglect
    - Preventing or controlling disease, injury, or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs
    - Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities**. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with laws and the heath care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but we will make an effort to inform you of the request.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena, or similar legal process
    - To identify and/or locate a suspect, material witness, fugitive, or missing person

5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

6. **Serious Threats to Health of Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **Military.** Our practice may disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide health care services to you, (b) for safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. **Worker's Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communication.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication you may make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members, and friends. If there is a request to withhold information from a non-custodial parent, we will ask for copies of the relevant court orders. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you or to operate our business in regard to treatment provided to you (i.e. billing, insurance matters). In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Privacy Officer named on page 2 of this notice. Your request must describe in a clear and concise fashion:

    a. **the information you wish restricted**
    b. **whether you are requesting to limit our practice's use, disclosure or both**
    c. **the precise nature of the restrictions; and**

d. **to whom you want the limits to apply.**

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to the Privacy Officer named on page 2 of this notice in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer named on page 2 of this notice. Your must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request, as well as the reason supporting your request, in writing. Also we may deny your request if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the IIHI kept by or for the practice; c) not part of the IIHI which you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented; for example, the doctor sharing information with a psychologist or social worker, or the billing department using your information to file your insurance. All requests for an "accounting of disclosures" must be made in writing to the Privacy Officer named on page 2 of this notice and state a time period, which may not be longer than six (6) years from the date of disclosure. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of the notice of privacy practices. You may ask us to give you an additional copy of this notice or any subsequently revised notice at any time. To obtain a copy of the notice, contact the Privacy Officer named on page 2 of this notice.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer named on page 2 of this notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time **in writing**. After you revoke your

authorization, we will no longer use or disclose your IIHI for reasons described in the authorization. Please note that we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer:

Catherine Stern, Ph. D., 34 South Broadway, Ste. 702, White Plains, NY 10601

familyhealth

A S S O C I A T E S

NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

Family Health Associates is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment services that we provide to you. We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain concerning your protected health information. By federal and state law, we must follow the terms of the notice of the privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your protected health information.
- Your privacy rights with regard to your protected health information.
- Our obligations concerning the use and disclosure of your protected health information.

The terms of this notice apply to all records containing protected health information that are created and retained by Family Health Associates.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF FAMILY HEALTH ASSOCIATES' PRIVACY PRACTICES NOTICE, AND UNDERSTAND THAT FAMILY HEALTH ASSOCIATES IS REQUIRED TO MAINTAIN THE PRIVACY OF MY HEALTH INFORMATION IN ACCORDANCE WITH ITS TERMS. I FURTHER ACKNOWLEDGE THAT I HAVE READ FAMILYHEALTH'S MEDICAL AND ADMINISTRATIVE POLICIES.

_____ _____

Signature of Patient, Parent, or Guardian Date

family*health*

A S S O C I A T E S

NOTICE OF PRACTICE POLICIES

Thank you for entrusting your care with our practice. Family*Health* Associates is a private practice committed to providing the best and most advanced care to our patients. For this reason, we do not participate directly in any insurance plans.

Our administrative staff will assist you in obtaining reimbursement from your insurance company by providing properly coded receipts and/or other supportive documentation to submit to your insurance company for reimbursement.

Payment is ***required at the time of service***. *Any* accumulation of a balance could lead to delay in treatment including prescriptions, as well as treatment ceasing altogether. *We do not bill for services rendered.*

I have read and understand the NOTICE OF PRACTICE POLICIES and agree to its terms.

Patient Name: _____

Signature of Patient, Parent or Guardian: _____

Date: _____

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ASSOCIATES

NOTICE OF CANCELLATION & NO-SHOW POLICY

When scheduling your appointment, we set aside enough time to provide you with the highest quality care. We strive to provide excellent medical care to you and to all of our patients. Consistent with this, we have developed appointment cancellation and no-show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed that time cannot be used to treat another patient in need of care. We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficiently uses your time.

Should you need to cancel or reschedule, please contact our office as soon as possible, and no later than ***twenty four hours*** prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.
To cancel or reschedule an appointment with Dr. Escallon, Dr. Green, or Dr. Wachtel, email **pc@myfhany.com**.
To cancel or reschedule an appointment with all other professional staff, please email your clinician directly.

If you cancel with less than 24-hour notice, or fail to show for your appointment, you will be charged your normal fee.

I have read and understand the NOTICE OF CANCELLATION & NO-SHOW POLICY and agree to its terms.

Patient Name: _____

Signature of Patient, Parent or Guardian: _____

Date: _____

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Off-Line Credit Card Authorization Form

This form will authorize Family*Health* Associates to charge the account listed below for professional services rendered to:

_____
(Name of patient(s) for whom this card is to be used

Credit Card Information

Name as it appears on the card (please print clearly): _____

Credit Card Number: _____

Card Type: _____ Card Expiration: _____

Address:

_____

_____

Home #: _____ Cell #: _____

I understand that all broken and late-cancelled appointments will be charged to this account.

Signature: _____ Date: _____

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CONSENT FOR CARE

I, the patient or patient's legal representative, hereby grant permission to _____ to perform such assessments, evaluations, diagnosis, and psychotherapy for the treatment of mental, emotional, behavioral, addictive, and developmental disorders and disabilities as may be professionally deemed necessary or advisable. I also grant permission to communicate with the doctors, therapists, and staff at FamilyHealth Associates via telephone, mail, facsimile, and e-mail regarding my/ the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of psychotherapy is not an exact science and that no guarantees or promises have been made to me as to the result of assessments, evaluations, diagnosis or treatments.

_____ _____

Patient Printed Name **Patient DOB:**

_____ _____

Patient Signature **Date**

The authorization below is given on the patient's behalf because the patient is either a minor or is unable to sign.

_____ _____

Printed Name of Parent/ Legal Guardian **Relationship to Patient**

_____ _____

Signature of Parent/ Legal Guardian **Date**