Home Medical Administration and Billing Services, LLC

PO BOX 3203, Schenectady, NY 12303 (518) 346-3100 Office Fax 1-877-583-1284

FOR USE BY AVILA RETIREMENT COMMUNITY RESIDENTS

REGISTRATION PACKET

Thank you for contacting Home Medical Administration and Billing Service (HMAB). In order to assist you in the intake process, we have provided the following description of what you can expect in the following weeks:

This process can take several weeks, it is important to note the following information:

"If there is an emergency or illness during this waiting period, you are instructed to go to the Emergency Room or dial 911."

Until you have had a face-to-face visit with a medical provider and they have admitted you as a patient to the practice, you are still considered a patient of your current provider and should seek any needed medical services from that physician.

Steps to being admitted:

1. Complete the registration packet and return by either mail or fax to the information provided in the above letterhead. Packets **CANNOT** be dropped off in person. If questions arise during completion of the paperwork, call our New Patient Coordinator for assistance*. **DO NOT SEND AN INCOMPLETE PACKET**.
2. Upon receipt of your packet, we will create a chart and verify all of your personal and medical information. This process moves quicker if the packet we receive is completed correctly, with all forms signed and dated, and supporting documents are included.
3. We will obtain prior medical records. To help expedite this process the information you provide on the "Authorization for Release of Medical Records" form should be complete and accurate, listing medical providers, physicians, specialists, and hospitals visited the last 2 years.

Once the registration packet is completed and submitted to us you will then be placed on our wait list for admission. Currently there is about a 6 to 12 week wait for your first appointment, depending on the demographic area you reside in. For more information on your potential wait time is it is best to contact the New Patient Intake Coordinator at 518-346-3100. Please remember, when providers enter your home administer health services, they are conducting themselves within a professional capacity. The same health and safety concerns that occur in the workplace must be as closely adhered to during their time in your home. It is your responsibility to be sure your home environment poses no health or safety hazard to service providers entering the home.
This includes, but is not limited to:

1. restraining pets
2. securing all weapons/ammunition
3. refraining from smoking
4. keeping entryways and examination areas clear of debris and hazards
5. keeping residence free of vermin like mice and bed bugs and disease spreading insects (fleas, ticks, lice)

Failure to comply may result in providers refusing entry into the home and/or the termination of services.

*Providers should not be contacted in regards to new patient admissions. Should you have any questions or need further assistance, please call (518) 346-3100.

DO NOT SEND BACK INFORMATIONAL PAGES

Please complete registration packet in its entirety and sign where indicated. Include a clear enhanced copy of the front and back of your insurance card(s).

If you are signing on behalf of the patient include a copy (not original) of the Power of Attorney and Health Care Proxy.

Patient Registration

For use by Avila Retirement Community Residents

Patient Information: *Please PRINT all information and use* ***BLACK*** *ink*

Last Name ______________________

First Name ______________________

Prefix____ **Suffix**________ **MI**____

PATIENT Home Address: 30 COLUMBIA CIR

APT #

City ALBANY **State** NY

Zip: 12203 **+4** 5146

Home Phone # ______________________

Cell Phone # ______________________

Is it ok to leave a message at your home phone number: YES NO

Race ____________ **Ethnicity** ____________

Primary Language ______________________

D.O.B (xx/xx/xxxx) ____________

Gender

Male Female Choose not to disclose
Transgender:
Female to Male Transgender
Male to Female Transgender
Genderqueer, neither Male or Female

Marital Status

Married Single Divorced Separated
Widowed Legal Partner

Employment Status

Full-Time Part-Time Not Employed
Retired

Sexual Orientation

Heterosexual Homosexual Bi-sexual
Do not know
Choose not to disclose
Something else- describe:
____

PLEASE PROVIDE AN EMAIL ADDRESS FOR YOURSELF OR YOUR CAREGIVER/HCP/POA SO THAT PATIENT PORTAL ACCESS CAN BE GIVEN. THIS PROVIDES US WITH AN EASIER WAY TO COMMUNICATE WITH YOU REGARDING YOUR CARE.

Email ______________________

Guardian/Legal Representative/emergency contact Name: ______________________

Address: ______________________

Phone: ______________________ **Relationship to the Patient?**______________________

******YOU MUST INCLUDE COPIES OF INSURANCE CARDS THAT ARE LISTED BELOW-failure to provide them will result in a delay on your wait list status******

Primary Insurance Carrier: ______________________

ID#:______________________ **Group#** ______________________

Secondary Insurance Carrier:______________________

ID#:______________________**Group#**______________________

WE REQUIRE YOUR MEDICARE ID # ON FILE REGARDLESS IF IT IS YOUR PRIMARY INSURANCE-(required; not optional)

ID#: ______________________

HOSPITAL (PART A) Coverage start date: ______________________

MEDICAL (PART B) Coverage start date: ______________________

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the above answers and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

______________________ ______________________
Signature of Patient/ Responsible Party Date

Home Medical Administration and Billing Services, LLC

Patient Name:
DOB:
Today's Date:

Treatment and Payment Acknowledgement/Consent

Consent for Treatment

I hereby request and consent to medical /and or diagnostic treatment, by Providers contracted with HMAB and/or any other contracting Physician operating under HMAB, LLC, and hereby authorize such entities and their physicians, (and whomever he/she may designate as his/her assistant (s), including Residents) and employees to treat myself or minor(s) in my legal custody, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, medical or surgical procedures. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. New York state law authorizes health care providers to test patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient on the basis of deemed consent. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to test, I will be informed and given an opportunity to ask questions. I further consent to the taking of photographs for treatment and/or payment purposes.

Obligation of Payment

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, and/or other provider of health care benefits to any other contracting Physician, provider operating under Home Medical Administration and Billing Service, LLC (HMAB) for services rendered. I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to Home Medical Administration and Billing Services, LLC and/or it contracting Physician/provider of service for any charges not covered by my insurance, including co-payments, deductibles, co-insurance payments, and fees for non-covered services within 30 days of statement. If all charges are not paid when due to the contracting provider, the undersigned agrees to pay all costs of collections, including collection agency and attorney's fees in an amount not to exceed thirty three and one-third percent (33-1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral. I authorize doctor and/or his/her staff to initiate a complaint to the INSURANCE COMMISSIONER for any reason on my behalf. FORMS: There will be a $35.00 charge for forms completed by the physician/provider of service that include, but not limited to; disability, Physicals, Return to work after illness or Family Medical Leave, Housing forms.

Balance Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due immediately. I have been informed that a fee of $45.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only by money order. Please direct all billing inquires to 518-346-3100 ext 13.

Acknowledgments/Certifications

I, the patient/Legal Guardian/Power of Attorney, acknowledge and certify the following:

- I was provided (a) the "Patient/Family Rights & Responsibilities" and (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" on the date of this Agreement and was given an opportunity to ask questions about the information provided.
- I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the payment terms contained in this form.
- I certify that this form has been fully explained to me and I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws.

Advance Directive to be completed if patient is an adult (18 years or older): Does the patient have an advance directive" _________Yes __________ No

Consent to Share Medical Information with External Entities

I, the patient/Legal Guardian/Power of Attorney, acknowledge and certify that:

◯ **I consent** to share Medical data with external entities for the purpose of medical treatment

◯ I **do not** consent to share Medical data with external entities for the purpose of medical treatment

For a list of entities, please contact our office at 518-346-3100.

If signing on behalf of the Patient please submit a copy of a Power of Attorney or HCP

PATIENT NAME (Please Print)	Patient Date of Birth

SIGNATURE OF PATIENT/LEGAL GUARDIAN ______ RELATIONSHIP TO PATIENT/LEGAL AUTHORITY ______ DATE ______

Witness:______________________________ DATE ______

Homedical Administration and Billing Services, LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Donna M. Heffernan, MD
Robin J. Connolly, FNP
Craig A. Richie, ANP
Anita Farry, FNP

Patient Name (PRINT):__________________________________**D.O.B.:** _____________

INFORMATION TO BE RELEASED FROM: (PRINT)
Name of Primary Care Physician, Specialists, Hospitals and Health Care Agencies: (*use a separate sheet of paper if needed)*

1. ________________________________ __________________________ ____________________
Last Name, First Name or Hospital Specialty Phone Number
________________________________ __________________________ ____________________
Street Address **City** **ST, Zip code**

2. ________________________________ __________________________ ____________________
Last Name, First Name or Hospital Specialty Phone Number
________________________________ __________________________ ____________________
Street Address **City** **ST, Zip code**

3. ________________________________ __________________________ ____________________
Last Name, First Name or Hospital Specialty Phone Number
________________________________ __________________________ ____________________
Street Address **City** **ST, Zip code**

4. ________________________________ __________________________ ____________________
Last Name, First Name or Hospital Specialty Phone Number
________________________________ __________________________ ____________________
Street Address **City** **ST, Zip code**

INFORMATION TO BE SENT TO:
Home Medical Administration and Billing Services, LLC PO Box 3203,
Schenectady, NY 12303-0203
FAX: 1(877) 583-1284
Phone (518) 346-3100

INFORMATION TO BE RELEASED: (Check one)
________ The most recent two (2) years of medical records

________ Specific information (detailed description):____
PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
EXCLUDE the following from the records by initialing by each selection
________Drug/Alcohol abuse/treatments & diagnosis ________ Sexually transmitted disease(s)
________HIV/AIDS diagnosis/treatment/testing ________ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment.) I may revoke this authorization in writing. (To view the process for revoking this authorization, please read the Privacy Notice. It is also available at www.hmabny.com formally www.hmaany.com. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. Possible copying fee required.

Patient Name (PRINT): ______________________________ **D.O.B:** ____________________

Signature: ______________________________ **Date:** ____________________

Relationship to patient: ______________________________

If you are signing on behalf of a patient, you must include a photocopy (do not send original) of the HEALTH CARE PROXY and POWER OF ATTORNEY. Please note that the POWER OF ATTORNEY must identify HEALTH INFORMATION ACCESS.

PLEASE LIST ANY INDIVIDUALS WITH WHOM WE MAY DISCUSS THE FOLLOWING INFORMATION

Addendum to HIPAA Release form: Patient Name:______________________ DOB____________

PLEASE PRINT

Billing information release

Full Name ____

Address:____

Phone#: ____

Relationship to the patient:____

Full Name ____

Address:____

Phone#: ____

Relationship to the patient:____

Full Name ____

Address:____

Phone#: ____

Relationship to the patient:____

Medical Information release:

Full Name ____

Address:____

Phone#: ____

Relationship to the patient:____

Full Name ____

Address:____

Phone#: ____

Relationship to the patient:____

Full Name ____

Address:____

Phone#: ____

Relationship to the patient:____

I hereby authorize use or disclosure of protected health information about me as described above to the individuals listed above. I have been provided with and retained the Notice of Privacy Practices for Home Medical Administraton and Billing Services, LLC.

Signature: ____ Date: __________________

Relationship to patient: ____

Patient Name: Last Name, First Name MI ______________________ Date of Birth MM/DD/YYYY ______________

MEDICAL ADMISSION INFORMATION

Name of current Primary Doctor: ____
Who referred you and why? ____
Name of any nursing agencies/community programs currently involved in your care: ____________________

MEDICAL HISTORY

List all present and past medical conditions/problems/concerns. Please give approximate date of onset

- ☐ ______________________ ☐ ______________________
- ☐ ______________________ ☐ ______________________
- ☐ ______________________ ☐ ______________________
- ☐ ______________________ ☐ ______________________
- ☐ ______________________ ☐ ______________________

Childhood illnesses you've had: ☐chickenpox ☐measles ☐mumps ☐scarlet fever ☐rheumatic fever ☐polio

MEDICATIONS

List all medications and dosage (Include all over the counter medicines, herbal preparations and vitamins)

	MEDICATION	DOSE	FREQUENCY		MEDICATION	DOSE	FREQUENCY
☐				☐			
☐				☐			
☐				☐			
☐				☐			
☐				☐			
☐				☐			
☐				☐			

ALLERGIES

Please list all allergies

Are you allergic to any medications, insects, foods, or anything environmental, or seasonal? ☐ Yes ☐ No

	Name:	Type of reaction (ex: itching, rash, shortness of breath, swelling, diarrhea)
☐		
☐		

Patient Name: Last Name, First Name MI ____________________ Date of Birth MM/DD/YYYY ____________________

SURGICAL HISTORY

List all surgeries, including eye surgery and the date of each

□ ______________________________ □ ______________________________

□ ______________________________ □ ______________________________

□ ______________________________ □ ______________________________

□ ______________________________ □ ______________________________

REVIEW OF SYSTEMS

Please answer the following questions and provide additional details if needed

How tall are you? _____________ How much do you weigh? ____________

Functional Status: Are you ***ABLE*** to do the following on your own without assistance?

	YES	NO
Bathing	□	□
Dressing	□	□
Toileting	□	□
Feeding	□	□
Transfer	□	□
Take medicine	□	□

	YES	NO
Use the phone	□	□
Housekeeping	□	□
Laundry	□	□
Food preparation	□	□
Manage money	□	□
Shopping	□	□

PLEASE CIRCLE ALL THAT APPLY:

Fall Assessment

History of falls
Do you use: Crutches, Cane, Walker
Bedridden/Immobile
Wheelchair
Periods of Confusion
Forgetfulness

Constitutional: Do you have?

Loss of appetite
Fever/Chills
Weakness
Weight loss/gain
Night sweats
Sleep disturbance

Cardiovascular

Chest pain
Racing Heart/Palpitations
Leg swelling
Dizzy/lightheaded
History of heart problems

Cardiovascular(cont'd)

High/low blood pressure
Leg cramps

Respiratory

Shortness of breath
Chest congestion
Cough
Secretions (color/quantity)
Asthma/Emphysema
Tuberculosis
Oxygen use
Sleep apnea

Ears, eyes, nose, mouth, throat

Ringing in ears
Hearing loss
Problem chewing/swallowing
Dentures/missing teeth
Mouth/lip sores/pain
Earache
Runny nose

Patient Name: Last Name, First Name MI

Date of Birth MM/DD/YYYY

Ears, eyes, nose, mouth, throat (cont'd)
Nosebleeds
Post nasal drip
Sore throat
Snoring
Loss/blurred vision
Light sensitivity/eye pain
Glasses/contact lenses
Cataracts/glaucoma

Endocrinology
Fatigue
Excessive sweating
Excessive thirst
Excessive urination
Cold/heat intolerance

Gastroenterology
Nausea/Vomiting/Diarrhea
Constipation/bowel changes
Difficulty holding bowels
Hemorrhoids
Heartburn/bloating/belching
Abdominal pain
Blood in stools
Rectal prolapse

Urology
Problem starting/holding urine
Frequent urination

Do You Have?
Painful/burning urination
Blood in urine
Recurrent urinary infections
Kidney stones
Prostate/bladder cancer

Dermatology
Unexplained rash/itching/hives
Change in color of moles/skin
Dry/ sensitive skin
Sores or open areas
Skin Cancer

Neurology
Headache
Memory loss
Change in mental status

Neurology(cont'd)
Convulsions/seizures
Trouble walking
Excessive day sleeping
Inability to speak
Numbness/tingling
Paralysis/stroke
Pain: location, intensity

Psychiatric
Depression/sadness
Anxiety/nervousness
Mood changes
Agitation/anger
Behavior disturbances
Suicide Attempts

Heme/Lymph
Varicose veins
Easy bruising/bleeding
Anemia
Blood clots
Swollen glands
Leukemia/Lymphoma

Musculoskeletal
Joint swelling
Joint pain
Arthritis

Reproductive
Sexually active
Vaginal/penile/testicular pain Vaginal/
penile bleeding/discharge Vaginal/
penile sores
History of sexually transmitted
disease Breast lumps/masses/
tenderness Nipple discharge
Sexual concerns

______________________________ Patient Name: Last Name, First Name MI

______________ Date of Birth MM/DD/YYYY

Social History:

Employment status: ☐Retired, Year______ ☐Employed part time (<20 hrs/week) ☐Employed Full time (40 hrs/week) ☐Occupation___________________________☐ Job Title_______________________________

Highest education: ☐ Grade School ☐High School ☐1-2 years college ☐3-4 years college ☐PostGrad

Have you ever used street drugs? ☐ YES ☐NO If YES, please indicate what and when_______________

Have you ever used tobacco? ☐YES ☐NO If YES: ☐Cigarettes, #/day?_____# years?_____Quit date?_____
☐Pipe, #/day? ___# years?____Quit date?______ ☐Chewing tobacco times/day?___# years?___Quit date?_

Did you have a drink containing alcohol in the past year? ☐ YES ☐ NO **If YES**: Indicate how often
☐ Monthly or less ☐ Two to four times a month ☐ Two to three times a week ☐ Four or more times a week

FAMILY HISTORY
Please complete the table to the best of your knowledge

Family Member	Living (Yes/No)	Age (years)	Medical Conditions/Cause of Death
Mother			
Father			
Siblings (brothers & sisters)			
Children			

Family history of (check all that apply) :
☐ Heart attacks ☐Strokes ☐ Diabetes ☐Emphysema ☐Mental illness ☐Kidney disease ☐Liver disease
☐ Auto immune disease (ex: Crohn's, rheumatism) ☐ Alcoholism ☐Tuberculosis
☐ Neurodegenerative disease (ex: Lou Gehrig's, Parkinson's, Multiple Sclerosis)
☐ Cancer: ☐Lung ☐Prostate ☐Breast ☐Colon ☐Pancreas ☐Brain ☐Other_____________

PLEASE LIST ALL MEDICAL PROVIDERS, CASE WORKERS, HOME HEALTH AGENCIES AND/OR PRIVATE HIRES PATICIPATING IN YOUR CARE BELOW:

NAME: **SPECIALTY/INVOLVEMENT** **PHONE:**

____ ________________________

____ ________________________

____ ________________________

____ ________________________

 ____ ________________________

Your Pharmacy Information

Use this section to tell your prescriber where you want your prescriptions filled. This will help your prescriber keep track of your pharmacy information.

Your name: ______________________________

Date of Birth ______________________________

Your pharmacy (first choice): ______________________________

Pharmacy address: ______________________________

____

Pharmacy phone number: ______________________________

Pharmacy (second choice): ______________________________

Pharmacy address: ______________________________

____

Pharmacy phone number: ______________________________

Use this space for other information your prescriber may need to know:

____

____

____

____

____

____

CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to Home Medical Administration and Billing Services, LLC and its contracted providers (referred to as "Provider"), provide chronic care management services "(referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk for further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and setting. The provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligation

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only on practitioner can furnish CCM Services to you during a thirty (30) day period.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights

You have the following right with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30) day period of services. You may revoke this agreement verbally by calling **518-346-3100** or in writing to **Home Medical Administration and Billing Service, LLC, PO Box 3203, Schenectady, NY 12303-0203**. Upon receipt of your revocation, the Provider will give you written confirmation including the effective date of revocation.

Beneficiary (patient)

Signature (patient)

Print Name (Patient AND Date of Birth)

Date

Beneficiary's Representative and/or Caregiver
If Applicable

Signature

Print Name

Date

CONSENT AGREEMENT

FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to Home Medical Administration and Billing Services LLC and its contracted providers (referred to as "Provider"), provide chronic care management services "(referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk for further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and setting. The provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligation

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only on practitioner can furnish CCM Services to you during a thirty (30) day period.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights

You have the following right with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30) day period of services. You may revoke this agreement verbally by calling **518-346-3100** or in writing to Home Medical Administration and Billing Service, LLC PO Box 3203 Service,LLC, Schenectady Ny 12303-0203. Upon receipt of your revocation, the Provider will give you written confirmation including the effective date of revocation.

Beneficiary | **Beneficiary's Representative and/or Caregiver**

________________________ ________________________

COPY KEEP FOR YOUR RECORDS

Hixny Electronic Data Access Consent Form
Home Medical Administration and Billing Service, LLC

In this Consent Form, you can choose whether to allow Home Medical Administration and Billing Services, LLC to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), doing business as Hixny, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Home Medical Administration and Billing Services, LLC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Home Medical Administration and Billing Service, LLC's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Home Medical Administration and Billing Service, LLC may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT).

Please carefully read the information on the back of this form before making your decision. Your Consent Choices. You can fill out this form now or in the future.
You have two choices.

- ☐ **I GIVE CONSENT for Home Medical Administration and Billing Services, LLC to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Home Medical Administration and Billling Services, LLC to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

______________________________ ______________ ______________
Print Name of Patient Date of Birth Date

______________________________ ______________________________
Signature of Patient or Patient's Legal Representative Print Name of Legal Representative (if applicable)

____
Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information will be used

Your electronic health information will be used by Homedical Administrative Associates, LLC only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information about You Are Included

If you give consent, Homedical Administrative Associates, LLC may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

Where Health Information about You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Homedical Administrative Associates, LLC. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information about You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Homedical Administrative Associates, LLC's medical staff who are involved in your medical care; health care providers who are covering or on call for Homedical Administrative Associates, LLC's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Homedical Administrative Associates, LLC at: ______________; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (877) 690-2211.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Homedical Administrative Associates, LLC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Homedical Administrative Associates, LLC. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.

Home Medical Administration and Billing Services, LLC
Po Box 3203
Schenectady, NY 12303
(518) 346-3100

Patient Name: ____

D.O.B: ________________________

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

In connection with the medical services which I am going to receive from Dr. Donna Heffernan and/ or Nurse Practitioner's Robin Connolly, Craig Ritchie, Anita Farry:

☐ I consent to have photographs of me taken.

☐ I deny consent to have photographs of me take.

____ ***Date:*** ____________________
(Signature of responsible party/relationship if not patient

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for Home Medical Administration and Billing Services, LLC **(name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.**

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print **Patient** Name **and** Power of Attorney/Health Care Proxy if applicable

Date of Birth

Signature

Date

DOUBLE CHECK

Please, check that items are filled in and pages are signed and dated properly.

Did you . . .

- ☐ Answer EVERY question?
- ☐ Sign and date EVERY page?
- ☐ List previous medical providers INCLUDING hospitals on the "Release of Medical Records"? (missing information here will hold up your admission)
- ☐ Include copies of insurance cards, POA/HCP, and other supporting documents?

NOTICE: INCOMPLETE PACKETS WILL BE RETURNED

Home Medical Administration and Billing Services, LLC
PO Box 3203
Schenectady, NY 12303-0203

Donna M. Heffernan, MD
Robin J. Connolly, FNP
Craig A. Ritchie, ANP
Anita S. Farry, FNP

PATIENT PORTAL INFORMATION

HTTPS://HEALTH.ECLINICALWORKS.COM/HMAA

Do NOT return this page

Home Medical Administration and Billing Services, LLC is offering our patients secure internet access to their medical information online, so you may view your personal health record at any time or place with internet access inclusive of you smart phone device.

You will be given a username and password and will receive periodic updates through your personal e-mail address on file.

PATIENT BENEFITS

- Request prescription refills
- View medical records
- Receive available education materials
- View current and past medical billing statements
- Send NON-URGENT message to your provider and/or staff 24/7
- Receive health maintenance reminders

GET WEB-ENABLED for your Patient Portal Access

You will have access to our secure server with our username and password.

Please provide up with a NON-WORK/employment e-mail address, and you can access your personal health record from a smart phone device or your computer with an internet connection.

If you require more assistance or have questions, please feel free to call our office at

(518) 346-3100

***The Patient Portal is NOT intended for use in emergencies! If you require immediate assistance, please dial 911 or go to your nearest emergency room.**

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer .
PLEASE NOTE: THESE POLICIES WILL BE MADE AVAILABLE IN OTHER FORMATS AT YOUR REQUEST.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will also post the on our website.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to OCRMail@hhs.gov
The complaint form may be found at: www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.
You will not be penalized in any way for filing a complaint.

Notice of Privacy Practices

PATIENT RIGHTS AND RESPONSIBILITIES
KEEP FOR YOUR RECORDS Effective Date: November 2021

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. PLEASE NOTE: THESE POLICIES WILL BE MADE AVAILABLE IN OTHER FORMATS AT YOUR REQUEST.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer:

Stephanie Carpenter
Home Medical Administration and Billing Service
PO BOX 3203
Schenectady, NY 12303-0203 518.346.3100

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes: (INSIDE)

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public

Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.