

## **Albany Health Management Associates, Inc.**

582 New Loudon Road, Latham, NY 12110

Patricia A. Fennell, LCSW-R, President

(518) 782-0551 Fax (518) 783-4793

E-mail: [communications@albanyhealthmanagement.com](mailto:communications@albanyhealthmanagement.com) Web: [www.albanyhealthmanagement.com](http://www.albanyhealthmanagement.com)

### **Description of Services**

Albany Health Management Associates, Inc. is a private organization of healthcare providers and licensed professionals **established to:**

1. Create a respectful and safe environment in which the patient becomes an equal partner with the care provider in managing his or her health.
2. Offer an inclusive, integrative approach to chronic illness and trauma which considers the patient in his or her social and cultural environment.
3. Expand an integrative philosophy of treatment to the professional and lay community and effect health care policy changes reflective of this approach.

AHMA works with chronically ill and traumatized individuals, couples, families and groups. AHMA serves the needs of patients dealing with chronic illness and trauma in their everyday lives. Patients come from around the world for assessment, healthcare coordination, and therapy from our clinic's treatment team. Services are based on the Fennell Four Phase Treatment (FFPT)<sup>TM</sup> (Crisis, Stabilization, Resolution and Integration) and embrace the individual as an integration of body, mind and spirit within a social environment.

The clinician enters into a partnership with the patients, helping them map out their own life journeys and manage their health. Individuals suffering from symptoms such as sleeplessness, depression, pain, fatigue, interpersonal difficulties, feelings of being overwhelmed, or any of the symptoms frequently affecting those both physically and emotionally compromised, can find help here.

#### **Services include:**

##### **Clinical Treatment/Counseling**

- Individual/Couple/Family Therapy
- Education/Support/Therapy Groups (chronic illness, trauma, long term trauma, sex abuse, depression, anxiety)

##### **Rehabilitation Services**

- Disability Consultation
- Vocational (Career) Counseling
- Workplace Management
- Rehabilitation Counseling (individual/family)

##### **Health Education and Training**

- Patient Education
- Employer Consultation
- Healthcare Provider Consultation

##### **Case Management**

- Referral and Advocacy
- Healthcare Provider Consultation
- Preventative Healthcare Management
- Information Management

##### **Business consultations**

- Workplace review/management
- Disability/chronic illness integration
- Start-up consultation
- Innovation

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**Appointment Cancellation/Rescheduling and Payment Policies**

We realize your time is valuable and ask for the same recognition in return. Therefore, if you are unable to make **your appointment, please call our office at least 48 hours, two business days before your appointed date and time at (518) 782-0551 to record the cancellation** and to reschedule your appointment. Business days are considered as Monday through Friday only. If our office has adequate notice of 48 hours, we may be able to give your appointment slot to another patient in need of treatment. **Cancellations or “no shows” without 48 hours notice** will result in a charge for an office visit. Please leave your message with the office manager or on the answering machine with the time and date you called to cancel and a request to reschedule.

- We are aware that many of the people who work with us have a serious illness or difficulties that may at times, require the cancellation of an appointment. If you must cancel **but do not give a 2 business days notice**, we will attempt to fill your scheduled time as soon as we hear from you. If we are not able to fill your session time you will be responsible for full payment related to the cancelled appointment. A check made out to A.H.M.A. for that session should be sent to the address above within the next 5 business days after your missed session.
- If you are not able to attend a scheduled meeting with your clinician you may choose to have an individual session on the telephone during your scheduled appointment time. If you use Medicare or an Insurance plan, they will not pay for a telephone session. A check made out to A.H.M.A. for that session should be sent to the address above within the next 5 business days after your missed session.
- There may be an occasion when a situation occurs which might require an extended session for critical client needs making your waiting time longer than usual. We ask for your patience in these situations and assure you we will provide you with your full session time as soon as that is possible.

**FOR GROUP MEMBERS**

- Each group member is allowed one cancellation at no charge per year. All other group member cancellations will be responsible for full payment due at the next group session.  
Thank you for your assistance with these issues.

If you need further information or clarification, please contact our office at (518) 782-0551.  
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**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 THIS NOTICE CAREFULLY**

**A. OUR COMMITMENT TO YOUR PRIVACY** Our practice is dedicated to maintaining the privacy of your health records. This information about you, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (“PHI”). 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 this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

**B. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We do use an outside billing agency and they may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

**For Health Care Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, We may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

**Required by Law:** Under the law, we must make disclosures of your PHI to you upon your request. Our practice will use and disclose your PHI when we are required to so by federal, state or local law.

**C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information,

**2. Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law or oversight activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

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**3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.

**4. Law Enforcement.** We may release PHI if asked to do so by a law enforcement official. The use or disclosure will be made in compliance with the law.

**5. Serious Threats to Health or Safety.** Our practice may use and disclose your PHI 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.

**6. Military.** Our practice may disclose your PHI if you are a member of US or foreign military forces (Including veterans) and if required by the appropriate authorities.

**7. National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

**8. Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

**9. Workers' Compensation.** Our practice may release your PHI for workers compensation and similar programs.

**10. Business Associates.** We may disclose your Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.

**D. VERBAL PERMISSION/ AUTHORIZATION**

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

Use and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your AHMA clinician.

**1. Right to Request Confidential Communications.** 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. In order to request a type of confidential communication, you must make a written request to 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. Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. 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. In order to request a restriction in our use or disclosure of your PHI you must make your request in writing. 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; and (c) to whom you want the limits to apply.

**3. Right to Inspection and Copy.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to inspect and/ or obtain a copy of your PHI. 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. Another licensed health care professional chosen by us will conduct reviews.

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**4. Right to Amend.** 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 provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and 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 PHI kept by or for the practice; (c) not part of the PHI 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. Right to an 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 PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The First list you request is free of charge, but our practice may charge you for additional lists after this original request. Our practice has 30 days to respond to your request. 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 our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

**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 office submit the complaint 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 PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the purposes described in the authorization. Please note 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 our Privacy Officer, Patricia Fennell at (518) 782-0551.

**F. COMPLAINTS**

If you believe we have violated your privacy rights, you have the right to file with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

The effective legal date of this Notice is April 14, 2003.

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**Client Intake Form**

**Date of Initial contact:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Telephone Numbers:** (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

(Work) \_\_\_\_\_ (Employer) \_\_\_\_\_

(Emergency Contact) \_\_\_\_\_

**Presenting problem:**

\_\_\_\_\_  
\_\_\_\_\_

**Medical Information:**

\_\_\_\_\_  
\_\_\_\_\_

**Financial information** : \_\_\_ Self-Pay \_\_\_ Other party pays \_\_\_ Insurance pays

**Name/Address/Phone of other party paying** \_\_\_\_\_

**Insurance Plan:** \_\_\_\_\_ **Type of Coverage:** \_\_\_\_\_

**Insured's ID#:** \_\_\_\_\_ **Insured's Name & DOB:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_ **Insured's Employer or School Name:** \_\_\_\_\_

**Client's ID#:** \_\_\_\_\_

**Authorization #:** \_\_\_\_\_ **Date Verified:** \_\_\_\_\_

**Benefits:** \_\_\_\_\_ **Co-Pay:** \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Med Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Agreed service fee quoted:** \_\_\_\_\_

**Referral Source:** \_\_\_\_\_

Client will bill Insurer     Clinician will bill Insurer     Clinician will bill other party paying

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**Approval for Substitute Signature**

I, \_\_\_\_\_, agree that my signature below will serve as a substitute for my signature on all health insurance claim forms generated in the offices of Albany Health Management Associates, Inc for payment of services rendered to me. It is further agreed that from this date forward, the term "Signature on File," will replace my signature on any of these claim forms.

\_\_\_\_\_ 20\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

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**Release of Information Authorization Form**

I, \_\_\_\_\_, authorize any health care provider including, but not limited to any physician, nurse, social worker, psychiatrist, or therapist who has attended, examined, or treated me, or any health care facility at which I have been examined or treated, to furnish Albany Health Management Associates, Inc. or representative, with any and all information which may be requested regarding my past or present physical or psychosocial/psychiatric care, condition or treatment rendered therefore, and to allow Albany Health Management Associates, Inc. or representative to examine any records, which you may have regarding my care, condition or treatment.

I further authorize Albany Health Management Associates, Inc. to utilize the information obtained pursuant to this release for such purposes as Albany Health Management Associates, Inc may deem appropriate in providing services or obtaining same for me.

Such disclosure shall not be made contrary to the provisions 42 CFR relating to “Confidentiality of Drug Abuse Patient Records.”

Executed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
signature

\_\_\_\_\_  
print name

\_\_\_\_\_  
witness signature

\_\_\_\_\_  
print name

**PLEASE FORWARD requested materials and records to:**

ALBANY HEALTH MANAGEMENT ASSOCIATES, INC.

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**Signed Acknowledgements and Receipt of Notices**

*Initial each section and sign below*

**Consent for Services**

\_\_\_\_\_ I give full consent to participate in the services as provided and developed by Albany Health Management Associates, Inc.

**Privacy Policy**

\_\_\_\_\_ I have received a copy of the Albany Health Management Associates, Inc. Client Privacy Policy. This Notice describes how my health information may be collected, used, stored and disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of this Privacy Notice upon request.

**Appointment Cancellations and Fees Policies**

\_\_\_\_\_ I have read, discussed and understand the fees and appointment policies for service from Albany Health Management Associates, Inc. and accept full responsibility for all payments of all services.

\_\_\_\_\_ Date \_\_\_\_\_  
( Client Signature)

\_\_\_\_\_  
( Print Client Name)

\_\_\_\_\_  
(Signature of Client Representative)\*

\_\_\_\_\_  
(Relationship to Client)

\*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.