

# Avenues to Wellness

Walnut Avenue Associates, PC



## Outpatient Service Authorization and Permission to Treat

Patient's Name: (first, middle, last) \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Current Residence: (street, city, state, zip) \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

**May we leave a message at the telephone numbers listed above?** \_\_\_\_\_

**Email address for reminders:** \_\_\_\_\_

Parent/Guardian Name if under 18 years old: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address if not the same: \_\_\_\_\_

### Primary Insurance

**Commercial Insurance Name:** \_\_\_\_\_ **Customer Service Phone:** \_\_\_\_\_

**Mental/Behavioral Health Carrier:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Policy/ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **CoPAY/Colnsurance \$** \_\_\_\_\_

**12 digit Virginia Medicaid #** \_\_\_\_\_ **CoPay\$** \_\_\_\_\_

Circle one: Medicaid, Va Premier id \_\_\_\_\_, Optima id: \_\_\_\_\_ Aetna Better Health, Molina (Magellan) \_\_\_\_\_

Anthem Healthkeepers ID: \_\_\_\_\_ UHCCP: \_\_\_\_\_

**Medicare ID:** \_\_\_\_\_ **Medicare Advantage Plan:** \_\_\_\_\_

### Secondary Insurance

**Commercial Insurance Co:** \_\_\_\_\_ **Customer Service Phone:** \_\_\_\_\_

**Mental/Behavioral Health Carrier:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Policy/ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **CoPAY/Colnsurance \$** \_\_\_\_\_

**12 digit Virginia Medicaid #** \_\_\_\_\_ **CoPay\$** \_\_\_\_\_

Circle one: Medicaid, Va Premier id \_\_\_\_\_, Optima id: \_\_\_\_\_ Aetna Better Health, Molina (Magellan) \_\_\_\_\_

Anthem Healthkeepers ID: \_\_\_\_\_ UHCCP: \_\_\_\_\_

**Medicare ID:** \_\_\_\_\_ **Medicare Advantage Plan:** \_\_\_\_\_

- I authorize the release of any medical or other information necessary to process my medical insurance claims; I authorize payment of medical benefits to Walnut Avenue Associates, PC: I understand that I will be responsible for any co-pay due to Walnut Avenue Associates, PC. at the time of each session. I understand that I am fully responsible for any unpaid balance should the insurance carrier not reimburse Walnut Avenue Associates, PC within 90 days of the invoice date.
- I hereby confirm that I am the patient or the custodial parent or legal guardian for the child named below and I authorize the provision of medical services. I understand that services may include, but may not be limited to, a psychiatric assessment, prescriptions for medications, lab orders and drug screens. I am aware that nearly all medications carry the potential for unintended side effects. If medications are prescribed, I understand that I have the right to be informed of the potential benefits and known potential side effects of such drugs, and that Walnut Avenue Associates, PC medical staff will provide information about potential medication benefits and side effects to me.

Patient/Parental/Guardian/Authorized representative signature gives Walnut Avenue Associates, PC permission to treat myself/ the person listed above/my child and obtain emergency medical care while in our office.

\_\_\_\_\_  
Patient (if over 18 years old)/Parent/Guardian/Authorized rep/Foster parent/SW Date

# Avenues to Wellness

Walnut Avenue Associates, PC



## Psychiatric Background Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ pounds Gender Identification: \_\_\_\_\_

Preferred Pharmacy Name \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Address and ZIP \_\_\_\_\_

## PSYCHIATRIC HISTORY / INFORMATION

In your own words, briefly state the reason why the patient needs to see a Psychiatrist and when did these symptoms begin?

Current Medications:	Dosage:	How long has the patient taken it:	Prescribing Doctor:

Previous Psychiatric Medications:

Has the patient previously been treated by a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient previously been treated by a Therapist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient previously been hospitalized for psychiatric reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No
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## LEGAL HISTORY

Has the patient ever had legal charges?       Yes       No

If yes, please explain?

**FAMILY HISTORY / INFORMATION**

Is the patient's parents divorced or separated?  Yes  No      If yes, what age was the patient when they separated?

Is the patient adopted?  Yes  No      If yes, at what age and does the patient know:

List all current party's living in the home:	Name:	Age:	Relationship to the patient

*Family history diagnosed by a physician, Please check all that apply:*

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manic Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the patient have a history of physical, verbal, or sexual abuse?  Yes  No

If yes, please explain:

**DEVELOPMENTAL HISTORY**

Were there any difficulties or complications for the mother or child during delivery? (Breathing problems, cord around the neck, problems feeding)  Yes  No If yes, please explain:

Did the mother suffer from any illnesses during pregnancy  Yes  No

Please check any substances that were used during pregnancy:

<input type="checkbox"/> Tobacco	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Illegal Drugs	<input type="checkbox"/> Prescription Medications	<input type="checkbox"/> Other
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If any are checked, please explain:

Was the pregnancy full term?  Yes  No

If no, please explain:

**SCHOOL HISTORY**

School Currently Attending or Highest Level of Education if an adult: \_\_\_\_\_ Grade: \_\_\_\_\_

School Attendance Record:  Excellent  Good  Poor

Has the patient repeated or skipped any grades?  Yes  No

If yes, please explain:

Has the patient had psychological testing?  Yes  No

If yes, please explain:

Has the patient ever had special education services or known learning disabilities?  Yes  No

If yes, please explain:

Does the patient currently have an IEP?  Yes  No

If yes, please explain:

**OCCUPATIONAL HISTORY**

Current Employer and position and start date:

Previous Employer, position and how long you worked there:

**SUBSTANCE USE HISTORY**

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Xanax, Valium, Klonopin	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Cocaine, Crack	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Suboxone, Methadone	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heroin or Opiates	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Synthetic Marijuana/ Marijuana	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
PCP, LSD, Mescaline	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines, Speed, Uppers, Crystal Meth	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Designer Drugs, Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Over-the-counter drugs	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
CBD Products	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Has the patient ever received substance abuse treatment?  Yes  No

If yes, please explain:

**MEDICAL HISTORY**

Has the patient ever had  Blackouts  DUI  Tremors  Hallucinations

Please check all that apply to the patient and list any additional medical history:

- Mumps     Measles     Chicken Pox     Seizures     Asthma     Heart Murmur     Thyroid  
 High Blood Pressure     Bowel or Bladder issues     Diabetes     Surgery     Flu  
 Other \_\_\_\_\_

Allergies to Medications:

To be signed by person completing form:

\_\_\_\_\_  
Print Name (Full Name)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature (Full Name)

\_\_\_\_\_  
Date

## Statement of Understanding

I have read, understand and accept the information provided on this handout about the practice as noted by my marks and signature below.

- ☐☐ 1.0 Office Hours:
- ☐☐ 2.0 Physician
- ☐☐ 3.0 Practice Parameters:
- ☐☐ 4.0 Appointments
- ☐☐ 5.0 Medication Refills
- ☐☐ 6.0 THC Use Policy
- ☐☐ 7.0 Initial Assessment
- ☐☐ 8.0 Inclement Weather
- ☐☐ 9.0 Emergency Procedures
- ☐☐ 10.0 Protection of Medical Information (HIPAA)
- ☐☐ 11.0 Patient Rights to Access Medical Information
- ☐☐ 12.0 Release of Medical Records
- ☐☐ 13.0 Permission to Treat a Minor Child
- ☐☐ 14.0 Billing and Insurance
- ☐☐ 15.0 Making a Complaint or Filing a Grievance
- ☐☐ 16.0 Technology Based Services
- ☐☐ 17.0 Client Rights

☐☐ I am the patient or the legal guardian or authorized representative for the patient.

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Signature

Date

**Authorization for Release of Information**

Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Case ID Number: \_\_\_\_\_

I hereby authorize: Avenues to Wellness affiliated with Walnut Avenue Associates, PC

Site Address: 16 Walnut Ave SW Roanoke VA 24016 540-345-6468, fax 540-345-3204  
*[Name and address(es) of physician, hospital, or health care provider]*

to release/obtain/exchange my personal health and medical information as described below with the following person(s):

\_\_\_\_\_

*[Name and address(es) of person(s) to receive/release/exchange information]*

**For the following purpose(s):**     Coordination of Care     Treatment Planning     Payment purposes  
 Emergency purposes     At client request     Other: \_\_\_\_\_

**This information includes (check all that apply):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Medical (Physical or Mental Health) Records/Lab | <input type="checkbox"/> Treatment Summary       | <input type="checkbox"/> Discharge Summary           |
| <input type="checkbox"/> Educational/Academic Records                    | <input type="checkbox"/> Behavioral Reports      | <input type="checkbox"/> Treatment Plan              |
| <input type="checkbox"/> Assessment/Clinical Evaluation                  | <input type="checkbox"/> Teacher Reports         | <input type="checkbox"/> Progress Notes              |
| <input type="checkbox"/> Psychiatric/Psychological Evaluation            | <input type="checkbox"/> Neurological Evaluation | <input type="checkbox"/> Drug Screen Results         |
| <input type="checkbox"/> Other (describe below):                         | <input type="checkbox"/> Court Report            | <input type="checkbox"/> Substance Abuse Information |

**The information to be shared covers the following dates of service:**

All dates of service    OR    From (date or event) \_\_\_\_\_ to (date or event) \_\_\_\_\_

**This authorization will expire on** \_\_\_\_\_ (fill in date or event), unless revoked by the undersigned.

This release, made freely and voluntarily, shall remain for the period noted above and may be revoked at any time with written notification executed by the responsible party noted below, except to the extent that action based on this consent has already been taken. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for treatment or benefits.

I understand that I may inspect or receive a copy of the information described on this form if I ask for it.

I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy, fax, or electronically transmitted version of this document has the same force and effect as the original.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/client's representative

\_\_\_\_\_  
Printed Name of Representative

\_\_\_\_\_  
Date

If signed by other than client, indicate relationship: \_\_\_\_\_

If prepared and/or witnessed by a AveWellWalnut Staff Member: \_\_\_\_\_ (Staff member name)

**Revocation of Authorization (if applicable):**

Date and time written notice of revocation of authorization received: \_\_\_\_\_

AveWell Walnut Staff who received notice for file and notified Privacy Officer (print name): \_\_\_\_\_

# Avenues to Wellness

Walnut Avenue Associates, PC



## Authorization for Release of Information

Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Case ID Number: \_\_\_\_\_

I hereby authorize: Avenues to Wellness affiliated with Walnut Avenue Associates, PC

Site Address: 16 Walnut Ave SW Roanoke VA 24016 540-345-6468, fax 540-345-3204  
*[Name and address(es) of physician, hospital, or health care provider]*

to release/obtain/exchange my personal health and medical information as described below with the following person(s):

list insurance: \_\_\_\_\_

*[Name and address(es) of person(s) to receive/release/exchange information]*

**For the following purpose(s):**  Coordination of Care  Treatment Planning  Payment purposes

Emergency purposes  At client request  Other: Billing and Insurance Audit

### This information includes (check all that apply):

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> Medical (Physical or Mental Health) Records/Lab | <input type="checkbox"/> Treatment Summary       | <input checked="" type="checkbox"/> Discharge Summary           |
| <input type="checkbox"/> Educational/Academic Records                               | <input type="checkbox"/> Behavioral Reports      | <input type="checkbox"/> Treatment Plan                         |
| <input type="checkbox"/> Assessment/Clinical Evaluation                             | <input type="checkbox"/> Teacher Reports         | <input checked="" type="checkbox"/> Progress Notes              |
| <input checked="" type="checkbox"/> Psychiatric/Psychological Evaluation            | <input type="checkbox"/> Neurological Evaluation | <input checked="" type="checkbox"/> Drug Screen Results         |
| <input type="checkbox"/> Other (describe below):                                    | <input type="checkbox"/> Court Report            | <input checked="" type="checkbox"/> Substance Abuse Information |

### The information to be shared covers the following dates of service:

All dates of service OR From (date or event) Beginning of treatment\_ to (date or event) \_ the end of services and payment related transactions

This authorization will expire on \_until the end of services and payment related transactions\_ (fill in date or event), unless revoked by the undersigned.

This release, made freely and voluntarily, shall remain for the period noted above and may be revoked at any time with written notification executed by the responsible party noted below, except to the extent that action based on this consent has already been taken. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for treatment or benefits.

I understand that I may inspect or receive a copy of the information described on this form if I ask for it.

I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy, fax, or electronically transmitted version of this document has the same force and effect as the original.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/client's representative

\_\_\_\_\_  
Printed Name of Representative

\_\_\_\_\_  
Date

If signed by other than client, indicate relationship: \_\_\_\_\_

If prepared and/or witnessed by a AveWell Walnut Staff Member: \_\_\_\_\_ (Staff member name)

### Revocation of Authorization (if applicable):

Date and time written notice of revocation of authorization received: \_\_\_\_\_

AveWell Walnut Staff who received notice for file and notified Privacy Officer (print name): \_\_\_\_\_

# Avenues to Wellness

Walnut Avenue Associates, PC



16 Walnut Avenue, SW Roanoke VA 24016  
540-345-6468 phone, 540-345-3204 fax

## **1.0 Office Hours:** *(subject to change depending on provider)*

Monday – Thursday from 7:30 a.m. - 5:00 p.m. Closed Friday

## **2.0 Providers:**

Jitendra Desai, MD

Sarah Rodes, PA-C

Michelle Whittaker, FNP-BC

Jessica Gillispie, PA-C

## **3.0 Practice Parameters:**

This practice is **strictly outpatient**. The Physicians and the PA's see patients during regular business hours only. Calls placed to the office outside of regular business hours will be returned within 1 business day. *In addition to the medication management services our providers **strongly** recommend additional supportive services and counseling for patients.*

## **4.0 Appointments:**

Clients are required to keep scheduled appointments to ensure successful, appropriate, and ethical ongoing treatment. The office requires 24 hours advance notification for cancellations. For Monday appointments please notify the office by 5pm on Thursday. Failure to attend an appointment is unacceptable and will lead to the patient being discharged. In order to serve a growing need for Psychiatric care at our office we ask for your close attention to times and dates of scheduled appointments and appreciate promptness so that other patients are not inconvenienced or delayed. A no-show to a scheduled appointment means that some other patient will not have opportunity for clinical care at that time.

To assist families who are waiting for an opening, we have adopted a strict no-show policy. We will be unable to continue providing psychiatric services to any patient who either misses three (3) appointments in a calendar year, two consecutive appointments, or cancels two times in less than 24 hours within the calendar year. Cancellations on the day of an appointment or arrive 5 minutes late are considered missed appointments. Also, we will be unable to reschedule patients who miss their first initial evaluation.

## **5.0 Medication Refills:**

Keeping scheduled appointments is important to maintaining your treatment and prescriptions. Should you miss an appointment, it is likely that your prescription will run out. In this instance, you must call your pharmacy for a refill five to seven days **before** your medication runs out. Two to three business days are required to process refill requests. Lost, stolen, or misplaced prescriptions will not be filled automatically. Random drug screens will be done at the discretion of the prescriber.



## **6.0 THC Use:**

THC possession laws have changed in Virginia effective 7/1/2021. However, this does not change the office policy to discourage the use of THC with controlled substances and psychiatric medications. It can alter the therapeutic effect of the medications prescribed and mask psychiatric symptoms.

Some insurance panels require periodic urine drug screens. Testing positive for THC could possibly cause your insurance prior authorization to be denied by insurance.

## **7.0 Initial Assessment:**

Initial assessments are conducted by the provider to:

- gather data by which the provider can make informed recommendations to the patient about therapies, medications, and testing which may be indicated by his/her circumstances and condition,
- establish an initial rapport which will facilitate effective treatment and evaluate any potential suicidal/homicidal ideation by means of a mental status exam. If such ideation is present, a risk assessment is conducted, and adequate protective interventions, including referral for hospitalization if necessary, are made by the psychiatrist and documented. If further treatment is indicated following the assessment process, appropriate referrals for testing, medication, adjunctive therapies, community resources and the like will be made at this time.

## **8.0 Inclement Weather:**

Inclement weather notifications are posted on the office voicemail. Please call (540) 345-6468 after 7:15 a.m. for weather related information.

## **9.0 Emergency Procedures:**

An emergency situation is an extremely critical and/or life-threatening situation that requires immediate professional attention. **If you should have an emergency, do not call or email the office, Instead, we ask you call:**

**Emergency Services: 911**

**Connect: (540) 981-8181 or (800) 284-8898**

## **10.0 Protection of Medical Information (HIPAA):**

*HIPAA* is the Health Insurance Portability and Accountability Act. This federal law requires that we inform patients of the control they have over their medical information and how their information is used and the reasons it can be disclosed to other parties.

## **11.0 Patient Rights to Access Medical Information:**

**As a patient, you have the right to:**

- Copy and review your individual medical records
- Request amendments to your medical records
- Receive an accounting of individuals who have accessed your medical records
- Restrict access to your records, beyond those placed by office policy
- Request specific ways to communicate with you

Whenever using and disclosing Protected Health Information (PHI) or when requesting PHI from another covered entity, we will make reasonable efforts to limit PHI disclosure to the minimum necessary required to accomplish the intended purpose of the use, disclosure or request.

### **12.0 Release of Medical Records:**

As a covered entity, it is within our legal right to use and disclose protected health information without express authorization for the following purposes:

- Oversight of the health care system – Quality Assurance
- Research with Institutional Review board approval or to prepare a research protocol
- Public health, and in cases of emergency
- Judicial and administrative proceedings
- Professional judgment – when in the best interest of the patient
- To provide information to next-of-kin, if a patient cannot speak for themselves
- For identification of the body of a deceased person
- For facilities (Hospitals, etc...) directories
- In other situations where the use of disclosure is mandated by law and consistent with the requirements of the law.

However, we **cannot** release your medical records for use without your express permission in the following situations:

- Protected Health Information beyond treatment, payment and operations functions
- Information covered by a restriction
- Research that includes treatment

**If you would like to have your medical records released to yourself or another party, you must first complete an authorization form. This form details the specific types of information you would like released and to whom you would like the records delivered.**

### **13.0 Permission to Treat a Minor Child:**

Please note that we require written permission from a parent or guardian to treat a minor child (any child under the age of 18).

- When parents are married the signature of one parent is sufficient to provide treatment.
- If the patient's parents are divorced, we require the signature of the parent having legal custody of the child.

We cannot provide any level of treatment to any child unless the proper signed consent form(s) is on file.

### **14.0 Billing and Insurance:**

**You must provide a current copy of your insurance card (front and back) before we can determine your benefits and insurance filing requirements. Please bring your insurance card to each appointment.**

We make every effort to verify your insurance benefits for outpatient mental health and substance abuse services in advance of your first appointment. However, we request that you contact your insurance company to check benefits and preauthorization requirements when you schedule your first appointment. Some

companies require preauthorization or a PCP referral. Your failure to follow this procedure could result in not obtaining your maximum benefits or any benefits at all.

**Please be aware that:**

If you choose to use your insurance benefits, your insurance company or the company which manages your mental health and/or substance abuse benefits, may require specific information regarding your case to determine the benefits available to you. We require specific written permission to release information to your managed care company.

This office will make every effort to file claims correctly and adhere to the filing requirements for your insurance policy. However, we cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services, **you are ultimately responsible for payment.**

Insurance policies are contractual agreements between you, "the subscriber," and your insurance company. Our office cannot alter your insurance policy, guarantee what services are covered or determine exactly what your reimbursement will be. Insurance companies sometimes exclude certain diagnostic codes or treatment modalities; therefore, it is impossible to guarantee coverage until a claim is filed and a response is received from your insurance carrier.

Walnut Avenue Associates, PC will only bill to insurance carriers if your insurance information (and a copy of your insurance card) is provided in advance of services being provided. If a balance is transferred to you because we do not have the information necessary to bill your insurance carrier, you will be responsible for that balance due. We will not be able to back-bill your insurance, even if your insurance information is provided at a later date.

**15.0 Making a Complaint or Filing a Grievance**

To all clients of Avenues to Wellness:

If you are dissatisfied with the services being provided by us or if you wish to file a grievance against perceived unfair treatment, the following procedures must be followed:

1. Explain your concern, complaint, or grievance to the Avenues staff providing the service.
2. If the conflict is not resolved, or if you do not feel comfortable making the complaint to the Avenues staff member, request the name and method of contacting the supervisor of the Avenues staff member.
3. If conference with the immediate supervisor does not end in a satisfactory resolution, you may contact the corporate office contact person identified below.
4. If you are still dissatisfied after talking with the person in the corporate office, you may contact the DBHDS Regional Advocate's Office identified below.

The above steps are provided in sequence. Some steps may be eliminated if you wish. For example, the initial complaint may be made directly to the corporate office.

After each step in the process, you will receive written notice of the actions taken as a result of the complaint. Copies of all information concerning your complaint or grievance will be kept in the corporate office.

**Medical Practice Administrator: Amy Stone**  
**16 Walnut Ave SW**  
**Roanoke VA 24016**  
**540-345-6468**

**Regional Advocate: Anne Camporini**  
**DBHDS-OHR Region III**  
**1-804-621-3032**

## **16. Technology Based Services**

Technology Based Service Delivery for Psychiatric Assessments and Medication Management may be provided by way of Tele Psychiatry in the state of Virginia. This approach will allow our providers to see, hear, and interact with patients from a remote location and provide services at a distance. Walnut Avenue Associates, PC will utilize a Tele Specialized Cloud-Based Platform that is Secure and HIPAA compliant. The Medical Provider's at Walnut Avenue Associates, PC are licensed within the State of Virginia and other governing bodies for which their license requires. Walnut Avenue Associates, PC will use company owned computer and equipment to provide Tele Psychiatry services to patients. Privacy and Security measures put in place through Walnut Avenue Associates, PC policy will be followed. All information gathered during a Tele Psychiatry Session will be documented within a separate Electronic Medical Record platform. When engaging in Tele Psychiatry clients will be notified about provider credentials, location, contact information, diagnosis, medication recommendations, drug interactions, and service recommendations. The staff is competent in the equipment, software, privacy, and confidentiality. Emergency Crisis situations will be dealt with immediately and the use of local emergency numbers and services will be utilized. By signing the Statement of Understanding I have read the above information regarding Walnut Avenue Associates, PC, use of Technology Based Services and have had an opportunity to have my questions answered.

## **16. Client Rights**

As a client of this program, you have certain rights, which are set out in the Rules and Regulations to Assure the Rights of Individuals Receiving Services for providers licensed by the Department of Behavioral Health and Developmental Services (referred to as Human Rights Regulations). A summary of your rights is set out below.

### I. RIGHT TO NOTIFICATION

You must be informed of your rights every six- (6) months while in the program, and you have the right to see and get a copy of the Community Regulations and the Policy upon request. Also, you must be told what the program's rules of conduct are, and you have a right to have a copy.

### II. RIGHT TO TREATMENT

Walnut Avenue Associates PC cannot deny services to you solely on the basis of your race, national origin, sex, age, religion or handicap, or ability to pay. If you think this company has discriminated against you, you can contact the Medical Practice Administrator, the Regional Advocate, or any program employee.

### III. RIGHT TO CONFIDENTIALITY

Your records will be released only with your consent or the consent of your authorized representative or by court order, except in emergencies or as otherwise permitted by law.

### IV. RIGHT TO CONSENT

A treatment or service which presents a "significant risk" – that is, one that might cause some injury or have a serious side effect – may not be administered unless you or your authorized representative first give informed consent to it.

### V. RIGHT TO DIGNITY

You have the right to be called by your preferred or legal name, to be protected from abuse, and to request help in applying for services or benefits for which you are eligible.

### VI. RIGHT TO LEAST RESTRICTIVE ALTERNATIVE

Your personal and physical freedom can be limited when necessary for your safety or the safety of other clients, or for treatment. You will be involved in decisions, which may limit your freedom, and you will be told what needs to happen for the limits to be removed.

### VII. RIGHT TO HEARINGS AND APPEALS

If you believe any of your rights under the Community Regulations has been violated you may file a complaint, and you may appeal the decision to the Medical Practice Administrator. In answering your complaints, Walnut Avenue Associates, PC staff must inform you of your appeal rights, which include the right to appeal a decision to the Local Human Rights Committee (LHRC).

### VIII. RIGHT TO ASSISTANCE BY REGIONAL ADVOCATE

The state has appointed a Regional Advocate to help clients and to make programs recognize client rights. The Advocate will help you in making, resolving or appealing complaints about rights violations. You can contact the Regional Advocate yourself and ask for help or NCG staff will help you to make the contact.

## **16. Notice of Privacy Practices**

This is found in the waiting room and provider's office. A copy can be given upon request.