Avenues to Wellness

Walnut Avenue Associates, PC

16 Walnut Avenue, SW Roanoke VA 24016
540-345-6468, fax 540-345-3204. Website: avewellwalnut.com

New Patient Paperwork

Thank you for your interest in scheduling an appointment with Avenues to Wellness. This is a psychiatric office prescribing medication for psychiatric diagnosis. Counseling and psychological testing are not a service offered here.
Our attendance policy is strict as there is a shortage of psychiatric providers in the area and want to make sure we are available for patients committed to their mental health. We are unable to reschedule new patient no shows and ask for a minimum of 48 hours to reschedule or cancel the new patient appointment. The office is open Monday through Thursday from 7:30am to 5pm.

The paperwork must be completed in its entirety. Make special note of the following:

- Complete, sign and date Outpatient Authorization and Permission to Treat
- Sign and date the Statement of Understanding,
- Sign and list your insurance carrier on the Authorization to Release Information for Insurance.
- Complete and sign the Psychiatric Background Information.
- An additional Authorization to Release Information is included for anyone, or agency, you want to have access to your information. Please be sure to include the individual/agency, their fax/telephone number, the date range, expiration date and what can be shared, or the form cannot be used.

Please note we are not in network with all insurance carriers, so please call the office a minimum of two business days of the appointment to report insurance changes, as we cannot guarantee you would be seen reporting insurance the same day as your appointment. If leaving a message be detailed leaving the carrier name and id number. 540-345-6468.

Please return the completed paperwork by either email, fax or in person to have your appointment scheduled.

- email billing@avewellwalnut.com
- fax: 540-345-3204
- In person: 16 Walnut Ave SW, Roanoke VA 24016, Monday through Thursday, 7:30am-4pm.

We look forward to working with you and appreciate your trust in Avenues to Wellness. Please call the office should you have any questions.

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/CoInsurance $_____

12 digit Virginia Medicaid #_____CoPay$_____
Circle one: Medicaid, Va Premier id _____, Optima id:_____ Aetna Better Health, Molina _____
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/CoInsurance $_____
12 digit Virginia Medicaid #_____CoPay$_____
_____
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.

_____
Signature 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? ☐ Yes ☐ No	Has the patient previously been treated by a Therapist? ☐ Yes ☐ No	Has the patient previously been hospitalized for psychiatric reasons? ☐ Yes ☐ No

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	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Manic Depression	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Suicide	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Obsessive/Compulsive Disorder	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐
Other Psychiatric Disorders	☐	☐	☐	☐

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

If yes, please explain:

DEVELPOMENTAL 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:				
☐ Tobacco	☐ Alcohol	☐ Illegal Drugs	☐ Prescription Medications	☐ Other

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?	
Alcohol	☐ Yes	☐ No			☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No			☐ Yes	☐ No
Xanax, Valium, Klonopin	☐ Yes	☐ No			☐ Yes	☐ No
Cocaine, Crack	☐ Yes	☐ No			☐ Yes	☐ No
Suboxone, Methadone	☐ Yes	☐ No			☐ Yes	☐ No
Heroin or Opiates	☐ Yes	☐ No			☐ Yes	☐ No
Synthetic Marijuana/ Marijuana	☐ Yes	☐ No			☐ Yes	☐ No
PCP, LSD, Mescaline	☐ Yes	☐ No			☐ Yes	☐ No
Inhalants	☐ Yes	☐ No			☐ Yes	☐ No
Caffeine	☐ Yes	☐ No			☐ Yes	☐ No
Nicotine	☐ Yes	☐ No			☐ Yes	☐ No
Amphetamines, Speed, Uppers, Crystal Meth	☐ Yes	☐ No			☐ Yes	☐ No
Designer Drugs, Ecstasy	☐ Yes	☐ No			☐ Yes	☐ No
Over-the-counter drugs	☐ Yes	☐ No			☐ Yes	☐ No
CBD Products	☐ Yes	☐ No			☐ Yes	☐ No

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.

_____

Signature Date

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):

_____

_____

[*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):

☐ Medical (Physical or Mental Health) Records/Lab	☐ Treatment Summary	☐ Discharge Summary
☐ Educational/Academic Records	☐ Behavioral Reports	☐ Treatment Plan
☐ Assessment/Clinical Evaluation	☐ Teacher Reports	☐ Progress Notes
☐ Psychiatric/Psychological Evaluation	☐ Neurological Evaluation	☐ Drug Screen Results
☐ Other (describe below):	☐ Court Report	☐ 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: _____

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 x☐ Other: Billing and Insurance Audit

This information includes (check all that apply):

x☐ Medical (Physical or Mental Health) Records/Lab	x☐ Treatment Summary	x☐ Discharge Summary
☐ Educational/Academic Records	x☐ Behavioral Reports	x☐ Treatment Plan
☐ Assessment/Clinical Evaluation	☐ Teacher Reports	x☐ Progress Notes
x☐ Psychiatric/Psychological Evaluation	☐ Neurological Evaluation	x☐ Drug Screen Results
☐ Other (describe below):	☐ Court Report	x☐ 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.

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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: _____

Revocation of Authorization (if applicable):
Date and time written notice of revocation of authorization received: _____
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Avenues to Wellness

Walnut Avenue Associates, PC

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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, PMHNP-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.

Rev 08/01/2023