

# Avenues to Wellness

Walnut Avenue Associates, PC



16 Walnut Avenue, SW Roanoke VA 24016  
540-345-6468, fax 540-345-3204. Website: [avewellwalnut.com](http://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 24 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 the No Show Policy
- Complete and sign the Psychiatric Background Information.
- An Authorization to Release Information can be provided should you want us to be able to communicate with another provider, office, or if a family member.

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](mailto: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.



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 which MCO: Medicaid, Sentara 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/Colnsurance \$** \_\_\_\_\_

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

Circle one which MCO: Medicaid, Sentara Aetna Better Health, Molina , 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 \_\_\_\_\_



**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 tried:  Esketamine (Spravato)  TMS  ECT

Has the patient previously been treated by a psychiatrist?  
 Yes  No  
 If yes, who?

Has the patient previously been treated by a Therapist?  
 Yes  No  
 If yes, who?

Has the patient previously been hospitalized for psychiatric reasons?  
 Yes  No  
 If yes, when and where?

**LEGAL HISTORY**

Has the patient ever had legal charges?  Yes  No

If yes, please explain?

<b>FAMILY HISTORY / INFORMATION</b>				
Are the patient's parents divorced or separated? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what age was the patient when they separated?		
Is the patient adopted? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<i>Family history diagnosed by a physician, Please check all that apply:</i>				
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please explain:				
<b>DEVELOPMENTAL HISTORY</b>				
Were there any difficulties or complications for the mother or child during delivery? (Breathing problems, cord around the neck, problems feeding) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
Did the mother suffer from any illnesses during pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> 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
If any are checked, please explain:				
Was the pregnancy full term? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, please explain:				
<b>SCHOOL HISTORY</b>				
School Currently Attending or Highest Level of Education if an adult:			Grade:	
School Attendance Record:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	
Has the patient repeated or skipped any grades?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:				
Has the patient had psychological testing?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:				
Has the patient ever had special education services or known learning disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please explain:				
Does the patient currently have an IEP?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:				

<b>OCCUPATIONAL HISTORY</b>						
Current Employer and position and start date:						
Previous Employer, position and how long you worked there:						
<b>SUBSTANCE USE HISTORY</b>						
SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Barbiturates	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Xanax, Valium, Klonopin	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cocaine, Crack	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suboxone, Methadone	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heroin or Opiates	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Synthetic Marijuana/ Marijuana	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
PCP, LSD, Mescaline	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inhalants	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caffeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nicotine	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Amphetamines, Speed, Uppers, Crystal Meth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Designer Drugs, Ecstasy	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Over-the-counter drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
CBD Products	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient ever received substance abuse treatment?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:						
<b>MEDICAL HISTORY</b>						
Has the patient ever had <input type="checkbox"/> Blackouts <input type="checkbox"/> DUI <input type="checkbox"/> Tremors <input type="checkbox"/> Hallucinations						
Please check all that apply to the patient and list any additional medical history:						
<input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Seizures <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Thyroid <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Bowel or Bladder issues <input type="checkbox"/> Diabetes <input type="checkbox"/> Surgery <input type="checkbox"/> Flu <input type="checkbox"/> Other _____						
<input type="checkbox"/> Allergies to Medications, please list:						
_____						

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



**NO SHOW POLICY**

Avenues to Wellness strives to provide exceptional patient care for every patient, every visit. To help achieve this level of care for all patients, it is important you notify us in a timely manner if you are unable to keep your appointment. This allows other patients access to this valuable time. Appointments can be canceled/rescheduled by calling 540.345.6468.

We reserve the right to charge a fee for any scheduled appointment that you:

- Cancel with less than 24 business hours' notice
- Fail to show (includes arriving more than 5 minutes late to any type of appointment)

Fees for late cancellation/missed appointments are (\*subject to change without notice):

- Office Visit: \$ 50.00 (subject to change at the office discretion.)

Fees are NOT billed to insurance and are the sole responsibility of the patient. Fees must be paid before rescheduling is allowed.

**Dismissal from Practice**

An existing patient will be dismissed from the practice:

- After the third instance within any 12-month period of failing to show for or failing to provide timely notification of cancellation of an office visit or in-office procedure (missing either type of appointment counts towards the total of 3).
- When you fail to show for or fail to provide timely notification to cancel or reschedule two consecutive appointments.

**New Patients**

Patients yet to be seen by a provider of Avenues to Wellness are subject to the following policy:

- A \$50.00 fee will be charged to a patient who cancels their initial appointment with less than 24 business hours' notice or fails to show for the appointment. Rescheduling of the initial appointment is allowed after the fee has been paid.
- If the patient cancels the rescheduled initial appointment with less than 24 business hours' notice or fails to show for the rescheduled initial appointment, the patient will not be allowed to reschedule with any provider.

I understand fees are charged for late cancellation or missed appointments. Also, based on the above policy, I understand that I can be dismissed from the practice depending on the appointment type and the number of times this happens.

Fees are not charged to patients who are covered under any Medicaid funded health care program. However, the policy for dismissal from practice for late cancellation and failing to show for Appointments will apply.

Patient Name (printed): \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name (printed) If Patient Is Minor:  
\_\_\_\_\_

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# 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**

**Amaninder “Amy” Grewal PMHNP-BC, DNP**

## **3.0 Practice Parameters:**

This practice is **strictly outpatient**. The Physicians/PA/PMHNP-BC 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 4pm 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 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 report insurance changes two business days before your scheduled appointment.

### **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 use 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: Mandy Crowder**  
**DBHDS-OHR Region III**  
**1-877-600-7159**

### **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.