

Avenues to Wellness

Walnut Avenue Associates, PC



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

ADHD Clinic Paperwork

Please complete the following forms and bring them to the scheduled appointment. It is very important they are completed in their entirety.

Explanation of forms:

- Outpatient Service Authorization and Permission to Treat includes demographics and insurance.
- Statement of Understanding; acknowledgement of receiving and understanding the practice parameters and rules of the practice included in the new patient paperwork.
- Authorization for Release of Information; the first one should include the insurance payer and is prefilled with what an insurance company would ask for in a chart audit.
- Authorization for Release of Information; blank for a PCP, counselor, school, family member, etc. Additional forms available on the website or at the office.
- ADHD Questionnaire
- NICHQ Vanderbilt Assessment Scale for PARENT; to be completed by the parent.
- NICHQ Vanderbilt Assessment Scale for TEACHER; to be completed before the initial appointment by the teacher.
- Avenues to Wellness practice parameters and office rules. Please read and let us know if you have any questions.

Each patient is required to bring a completed TEACHER'S form to each follow up appointment or the appointment may need to be rescheduled. The forms can be found on our website under the FORMS tab or picked up at the front office. Website: avewellwalnut.com

If your child misses two (2) scheduled ADHD appointments, we will not refill any more prescriptions. After three (2) missed appointments your child will be released from the ADHD clinic, no exceptions will be made.

Each patient is required to have a yearly physical in addition to a three (3) month follow-up as indicated by physician for height/weight checkup while taking medication. It is very important to monitor labs, weight, home and school behaviors. If your child has not had a checkup lately, please call for an appointment.

ADHD Medication will be filled on Wednesday, call at least 3 days before. Call 540-345-6468 and include the patient's name, date of birth, medication name and current pharmacy. The medications are sent electronically.

Please call the office should you have any questions regarding the forms or the upcoming appointment; 540-345-6468.

Revised 07/01/2021

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

Revised 07/01/2021

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

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: _____

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): _____

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):

PCP Agency and Doctor Name: _____

[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): _____

TO BE COMPLETED BY THE PARENT

NAME OF CHILD: _____ INTERVIEW DATE: _____

INTERVIEWER: _____ INFORMANT: _____

*****PLEASE CIRCLE THE ANSWERS ON THE FOLLOWING QUESTIONNAIRE*****

REASON FOR REFERRAL:

REFERRAL SOURCE:

PARENTAL OBJECTIVES:

I. DEVELOPMENTAL FACTORS

A Prenatal History

| | |
|--|---|
| 1. How was your health during pregnancy? Circle your answer. | Good Fair Poor I don't know |
| 2. How old were you when your child was born? | _____ years old |
| 3. Any use of alcohol during pregnancy? (circle your answer) | a. Never b. Once or twice c. 3-9 times d. >10 times |
| 4. Cigarette uses during pregnancy? (circle your answer) | a. Never b. Once or twice c. 3-9 times d. >10 times |
| 5. Coffee or other caffeine (Cola, etc.) Taken together, how many times? | a. Never b. Once or twice c. 3-9 times d. >10 times |
| 6. Did you ingest any of the following substances? | a. ___ Valium (Librium, Xanax, Valium) b. ___ Tranquilizers c. ___ Antiseizure medications (e.g. Dilantin) d. ___ Treatment for diabetes e. ___ Antibiotics (for viral infections) f. ___ Sleeping Pills g. ___ Other (please specify: _____) |

B. Perinatal History

| | |
|---|---|
| 7. Did you have toxemia or eclampsia? Circle your answer | Yes No I don't know |
| 8. Was the Rh factor incompatibility? Circle your answer | Yes No I don't know |
| 9. Was (s)he born on schedule? (circle your answer) | 8 mos. or earlier, Term 8-10 mos. , 10 mos, I don't know |
| 10. What was the duration of labor? | |
| 11. Were you given any drugs to ease the pain of labor? | List name of med: |
| 12. Were there indications of fetal distress during labor? Circle your answer | Yes No I don't know |
| 13. Was the delivery (please circle) | Normal? Breach? Cesarean? Forceps? Inducted? I don't know? |
| 14. What was the child's weight? | |
| 15. Were there any health complications following birth? | If YES, specify: |

C. Postnatal Period and Infancy

| | |
|--|---|
| 16. Were there early infancy feeding problems | Circle: No Yes I don't know |
| 17. Was the child colicky? | Circle: No Yes I don't know |
| 18. Were there problems with the infant's responsiveness? (alertness) | Circle: No Yes I don't know |
| 19. Were there early infancy sleeping pattern difficulties? | Circle: No Yes I don't know |
| 20. Did the child experience any health problems during infancy? | Circle: No Yes I don't know |
| 21. Did the child have any congenital problems? | Circle: No Yes I don't know |
| 22. Was the child an easy baby? Cry a lot? Did (s)he follow a schedule fairly well> | Circle: No Yes I don't know Circle: No Yes I don't know |
| 23. How did the baby behave with other people? | More schedule than ____ Average sociably ____ More unsociable than average ____ |
| 24. When (s)he wanted something, how insistent was (s)he? | Very _____, Average _____, not at all insistent _____ |
| 25. How would you rate the activity level of the child as an infant/toddler? | Very active _____, Average _____, not active _____ |

D. Developmental Milestones

| | |
|--|--|
| 26. At what age did (s)he sit up? Circle your answer | 3-6 mos., 7-12 mos., Over 12 mos., I don't know |
| 27. At what age did (s)he crawl? Circle your answer | 6-12 mos., 12-18 mos., Over 18 mos., I don't know |
| 28. At what age did (s)he walk? Circle your answer | Under 1 year, 1-2 years, 2-3 years, I don't know |
| 29. At what age did (s)he speak single words (other than "mama" or "dada")? Circle your answer | 9-13 mos., 14-18 mos., 18-24 mos., 26-36 mos. 37-48 mos., I don't know |
| 30. At what age did (s)he string two or more words together? Circle your answer | 9-13 mos., 14-18 mos., 18-24 mos., 26-36 mos. 37-48 mos., I don't know |
| 31. At what age was (s)he toilet trained? Circle your answer | Under 1 years, 1-2 years, 2-3 years, I don't know |

II MEDICAL HISTORY

| | |
|---|--|
| 32. How would you describe his/her health? | Circle your answer: Good Fair Poor |
| 33. How is his/her hearing? | Circle your answer: Good Fair Poor |
| 34. How is his/her vision? | Circle your answer: Good Fair Poor |
| 35. How is his/her gross motor coordination? | Circle your answer: Good Fair Poor |
| 36. How is his/her fine motor coordination? | Circle your answer: Good Fair Poor |
| 37. How is his/her speech articulation? | Circle your answer: Good Fair Poor |
| 38. Has he/she had any chronic health problems (e.g. asthma, diabetes, heart conditions)? | If YES, specify: |
| 39. When was the onset of any chronic illness? | |
| 40. Which of the following illness has the child had? | Circle your answer: Mumps, Chicken Pox, Measles, Whooping cough, Scarlet Fever, Pneumonia, Encephalitis, Otitis media, Lead Poisoning, Seizures, Other diseases: Specify |

| | |
|--|--|
| | |
| 41. Has the child had any accidents resulting in the following? Circle your answer | Broken bones, Severe lacerations, Head injury, Severe bruises, Stomach pumped, Eye injury, Lost teeth, Sutures, Other, specify: |
| 42. If Yes, to accidents, how many accidents? | |
| 43. Has he/she ever had surgery for any of the following conditions? Circle your answer | Tonsillitis, Adenoids, Hernia, Appendicitis, Urinary tract Eye, ear, nose & throat, Digestive disorder, leg or arm, Burns, Other: Specify: |
| 44. Is there any suspicion of alcohol or drug use? | Circle: Yes No I don't know |
| 45. Is there any history of physical/sexual abuse? | Circle: Yes No I don't know |
| 46. Does the child have any problems sleeping? | Circle: None, Difficulty falling asleep, Sleep continuity disturbance, Early morning awakening |
| 47. Does the child have any bladder problems at night? Does the child have any bladder problems during the day? | Circle your answer: Yes or No. If YES, how often? Circle your answer: Yes or No. If YES, how often? |
| 48. Does the child have bowel control problems? | Circle your answer: Yes or No |
| 49. Does the child have any appetite control problems? | Circle your answer: Over eats, Average, Under eats |

III TREATMENT HISTORY

| | |
|---|---|
| 50. Has the child ever had any of the following? If yes, list the duration in months. | Ritalin (methylphenidate) Yes, No, How long?_____ Concerta (methylphenidate) Yes, No, How long?_____ Adderall (amphetamine) Yes, No, How long?_____ Vyvanse Yes, No, How long?_____ Strattera (atomoxetine) Yes, No, How long?_____ Mydayis Yes, No, How long?_____ Tranquilizers Yes, No, How long?_____ Anticonvulsant Yes, No, How long?_____ Antihistamines Yes, No, How long?_____ Other prescription drugs: _____ |
| 51. Has the child ever had any psychological treatment? | Circle Yes or No. If YES, how long did it last? |

IV SCHOOL HISTORY

Please summarize the child's progress (e.g. academic, social, testing) within each of these grade levels:

Preschool _____

Kindergarten _____

Grade 1 through 3 _____

Grade 4 through 6 _____

Grade 7 through 12 _____

| | |
|---|---|
| <p>52. Has the child ever been in any type of special education program, and if so, how long?</p> | <p>Learning disability class _____ Behavioral/emotional disorder class _____ Speech & language therapy _____ Other (please specify): _____</p> |
| <p>53. Has the child ever been suspended from school? Has the child ever been expelled from school? Has the child ever been retained a grade?</p> | <p>Circle Yes or No. If YES, how many suspensions? _____ Yes or No. If YES, how many expulsions? _____ Yes or No. If YES, how many retentions? _____</p> |
| <p>54. Have any additional instructional modifications been attempted?</p> | <p>None _____ Behavioral Modification Program _____ Daily/Weekly report card _____ Other: please specify: _____</p> |

V. SOCIAL HISTORY

| | |
|--|--|
| <p>55. How does the child get along with his/her brothers/sisters?</p> | <p>Circle: Doesn't have any. Better than average. Average. Worse than average</p> |
| <p>56. How easily does the child make friends?</p> | <p>Circle: Easier than average. Average. Worse than average. I don't know</p> |
| <p>57. On the average, how long does your child keep friendships?</p> | <p>Circle: Let than 6 months. 6 months to 1 year. More than 1 year. I don't know</p> |

VI. CURRENT BEHAVIORAL CONCERNS

| Primary Concerns | Other Related Concerns |
|------------------|------------------------|
| | |

| | |
|--|---|
| 58. What strategies have been implemented to address these problems? | Circle your answer: Verbal reprimands. Rewards Time out (isolation). Physical punishment Removal of privileges |
| 59. On the average, what percentage of the time does your child comply with initial commands? | Circle your answer: Most of the time. Sometimes. Never |
| 60. On the average, what percentage of the time does your child eventually comply with your commands? | Circle your answer: Most of the time. Sometimes. Never |
| 61. To what extent are you and other caretakers consistent with respect to disciplinary strategies? | Circle your answer: Most of the time. Sometimes. Never |
| 62. Have any of the following stress events occurred within the past 12 months? | Circle your answer: Parents divorced or separated. Family accident or illness. Death in family. Family moved. Parent changed jobs. Changed schools. Family financial problems. Other: specify: |
| 63. How long have you and the child's parent been married? Please note if the child was product of 1 st or 2 nd , etc, marriage. | Circle your answer: Never married. Separated. Divorced. Widowed. Married for _____ years. |
| 64. How stable is your current marriage? | Circle your answer: Stable Unstable |

VII. FAMILY HISTORY

65.

| | |
|---|--|
| # of siblings and ages | |
| Problems with aggression, defiance & oppositional behavior as a child | |
| Problems with attention, activity, & impulse control as a child | |
| Learning disabilities | |
| Failed to graduate from high school. | |
| Mental Retardation. | |
| Psychosis or schizophrenia | |
| Seizure disorder | |
| Anxiety disorder that impaired adjustment. | |
| Tics or Tourette's | |
| Alcohol & Substance Abuse | |
| Diabetes | |
| Antisocial behavior (assaults, thefts, etc.) | |
| Heart problems | |
| Physical abuse | |
| Sexual abuse | |
| Other: | |

| | |
|--|--|
| | |
| <p>66. Which of the following are a significant problem at the present time?</p> <p>Stolen without confrontation _____</p> <p>Run away from home overnight at least twice _____</p> <p>Lies often _____</p> <p>Deliberate fire-setting _____</p> <p>Often truant _____</p> <p>Breaking and entering _____</p> <p>Destroyed others' property _____</p> <p>Cruel to animals _____</p> <p>Forced someone else into sexual activity _____</p> <p>Used a weapon in a fight _____</p> <p>Often initiates physical fights _____</p> <p>Stolen with confrontation _____</p> <p>Physically cruel to people _____</p> <p>TOTAL for Conduct Disorder* _____</p> <p>3 or more _____</p> <p>When did these problems begin? Specify age: _____</p> | <p>67. Which of the following are a significant problem at the present time?</p> <p>Unrealistic and persistent worry about possible harm to attachment figures. _____</p> <p>Unrealistic and persistent worry that a calamitous event will separate the child from attachment figure. _____</p> <p>Persistent school refusal _____</p> <p>Persistent avoidance of being alone _____</p> <p>Repeated nightmare, re: separation. _____</p> <p>Somatic complaints _____</p> <p>Excessive distress in anticipation of separating from attachment figure. _____</p> <p>Excess distress when separated from home or attachment figure. _____</p> <p>TOTAL for Separation Anxiety* _____</p> <p>When did these problems begin? Specify age: _____</p> |
| <p>68. Which of the following are significant problems at the present time?</p> <p>Unrealistic worry about future events _____ Unrealistic concern about appropriateness of past behavior _____</p> <p>Unrealistic concern about competence _____ Somatic complaints _____</p> <p>Excessive need for reassurance _____ Marked self-consciousness _____</p> <p>Marked inability to relax _____</p> <p>TOTAL for Overanxious Disorder _____ (4 or more)</p> | |

| | |
|--|--|
| <p>69. Which of the following are significant problems at the present time? Depressed or initiate mood most of the day, nearly every day.</p> <p>_____ Diminished pleasure in activities</p> <p>_____ Decreased or increase in appetite associated with possible failure to make weight gain.</p> <p>_____ Insomnia or hypersomnia nearly every day</p> <p>_____ Psychomotor agitation or retardation</p> <p>_____ Fatigue or loss of energy</p> <p>_____ Feelings of worthlessness or excessive inappropriate guilt.</p> <p>_____ Diminished ability to concentrate</p> <p>_____ Suicidal ideation or attempt</p> <p>_____ TOTAL for Major Depression Episode * (items 3-9) = (6 or more)</p> | <p>70. Which of the following are a significant problem at the present time? Often Intense temper</p> <p>_____ Often argues with adults</p> <p>_____ Often actively defies or refuses adult request or rules</p> <p>_____ Often deliberately does things that annoy people</p> <p>_____ Often blames others for own mistakes</p> <p>_____ Is often touchy or easily annoyed by others</p> <p>_____ Is often angry or resentful</p> <p>_____ Is often spiteful or vindictive</p> <p>_____ Often swears or uses obscene language</p> <p>_____ TOTAL for Oppositional Defiant Disorder</p> <p>_____ 5 or more When did these problems begin? Specify age: _____</p> |
| <p>71. Diagnostic Criteria</p> <p><u>Hyperactivity</u></p> <p>___ a. Often fidgets with hands or feet or squirms in seat</p> <p>___ b. Often leaves seat in classroom or in other situations in which remaining seated is expected.</p> <p>___ c. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescent or adults, may be limited to subjective feelings of restlessness.</p> <p>___ d. Often has difficulty playing or engaging in leisure activities quietly.</p> <p>___ e. Is often “on the go” or often actives as if “driven by a motor”.</p> <p>___ f. Often talks excessively</p> | <p><u>Impulsivity</u></p> <p>___ a. Often blurts out answers before questions have been completed.</p> <p>___ b. Often has difficulty awaiting turn.</p> <p>___ c. Often interrupts or intrudes on others (e.g. butts into conversations or games.)</p> |

Inattention

___a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.

___b. Often has difficulty sustaining attention in tasks or play activities.

___c. Often does not seem to listen when spoken to directly.

___d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace

(not due to oppositional behavior or failure to understand instructions.)

___e. Often has difficulty organizing tasks and activities.

___f. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork

or homework.)

___g. Often loses things necessary for tasks or activities (e.g. toys, school pencils, books or tools.)

___h. Is often easily distracted by extraneous stimuli.

___i. Is often forgetful in daily activities.

TOTAL for ADHD = _____ (6 or more)

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

Varsha 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. You may also send your refill request through the Patient Portal. Lost, stolen, or misplaced prescriptions will not be filled automatically. Random drug screens will be done at the discretion of the prescriber.

6.0 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.

7.0 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.

8.0 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 the office or use the Patient Portal. Instead, we ask you call:**

Emergency Services: 911

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

9.0 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.

10.0 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.

11.0 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.

12.0 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.

13.0 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.

14.0 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: Jennifer Kovack
DBHDS-OHR Region III
1-877-600-7437

15. 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.