WALSTON HEALTH SERVICES OFFICE RULES

Appointments

Your appointment time is reserved for you. Each appointment requires advanced preparation on our behalf to ensure a high level of attention and care specific to your needs. Therefore, if you are unable to keep your appointment, our practice requires a minimum of 24-48 hours' notice to cancel or reschedule. This will ensure that those patients on the waiting list will have access to any available appointments. We will make an attempt to contact you to confirm your appointment. This call/text/email is a courtesy and our failure to reach you will not relieve you of your responsibility for any missed appointment charges. **Failure to provide a 24-48 hours' notice will result in a charge of $75.00, which is not covered by your insurance.**

Prescriptions

Please request renewal prescriptions at the time of your appointment. You will be provided enough refills to last until your next expected appointment. **If you miss your appointment and require a refill prescription, you must let our office know one week before the medication runs out.** You will be provided enough medicine to last until your follow-up appointment, which must be made within one week's time.

Returned Checks

There is a $25 fee applied to all returned checks.

Private Pay

Charges for services are due at the time services are rendered. We accept: Cash, or Check. We accept Discover, Mastercard, or Visa as a direct courtesy to our patients.

Contracted Insurance

If you have health insurance, it is extremely beneficial and to your advantage to be aware of the coverage and details of your insurance benefit coverage. Your health insurance coverage is an agreement between you and your insurance company to pay certain amounts for your care and treatment. Your Physician's bill, on the other hand, is an agreement between you and your physician. **You are responsible for the payment of your doctor's bill(s).**

This practice directly contracts with carriers to provide behavioral health services for some insurance companies. As a convenience to you, our practice will verify your benefits and coverage eligibility. If you are enrolled with one of these companies, you are financially responsible for any co-pays, or deductible fees, which are predetermined by your insurance group or employer. **You will be asked to pay any co-pays, deductibles, and co-insurance at the time of service.**

Billing

Balances are due on the day you are invoiced by Walston Health Services, **after (30) days of the billing settlement date (invoice date) you will receive an automatic $50.00 late payment fee. Any delinquent balances thereafter will incur a 10% late payment charge per month.** If unusual financial circumstances exist, please call our practice to discuss payment options. This will avoid any misunderstanding and enable you to keep your account in good standing.

Collections

Except when previous payment arrangements warrant otherwise, accounts ninety (90) days past due are referred to a collection agency. **Any collection cost or attorney fees necessary for the collection of any outstanding debt of this practice will be charged and paid by the debtor.**

Discharge from Care

We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities. We will suggest referral options for this event.

Please sign and date this form, acknowledging that you have read and understood our policies. Thank you.

I hereby certify that I have read and understood this statement.

Signature:_____ **Date:** _____

Cancellation Policy

Your appointment time is reserved exclusively for you. Each appointment requires advance preparation on your behalf to ensure a high level of attention and care specific to your needs. Therefore, if you are unable to keep your appointment, our practice requires a minimum of **24 hours** notice to cancel or reschedule. Same-day rescheduling will follow the same protocol. This protocol has been put in place in order to ensure that those patients on the waiting list will have access to those appointments.

We will try to contact you to confirm each appointment. This is a courtesy and our failure to reach you will not relieve you of your responsibility for any missed appointment charges. **Failure to provide a 24-hour notice will result in a charge of $75.00, which is not covered by your insurance.**

By signing I am agreeing to the policy above.

Name:_____
Signature:_____
Date: _____

Patient's Bill of Rights

As a person receiving mental health services, you have the right to:

- Be treated with dignity and respect.
- Choose the services or programs in which you participate based on information about rules, treatment procedures, costs, risks, rights, and responsibilities.
- Ask questions and get answers about services.
- Participate fully in all decisions about treatment or services.
- Request changes in treatment or services.
- Receive treatment in the least restrictive setting - one that provides the most freedom appropriate to your treatment needs.
- Refuse treatment or service unless ordered by the Court to participate.
- Be informed about the rules that will result in discharge from a program if violated.
- Participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge unless your behavior threatens the well-being of another person.
- Know the name of the medication you are taking, why you are taking it, and what its possible side effects might be.
- Refuse to take medication if you choose. (Note: You should not discontinue taking the medication suddenly without first discussing the possible dangers with a psychiatrist.)
- Have your family involved in your treatment.
- Refuse family participation in your treatment if you choose.
- Not be subjected to verbal, physical, sexual, emotional, or financial abuse, harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result.
- File a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice, (i.e. family, friend, case manager, member of a consumer advocacy committee or organization, etc.)
- Review your record, with two exceptions. Limited portions of your records can be withheld from you if your treatment team leader has written that seeing specific information would, ◦be harmful to your treatment, or reveal the identity or break the trust of someone who has provided information in confidence.
- Decide who else can see your records, with several exceptions. Those who do not need to ask your permission are: people involved in your mental health treatment or to whom you are referred for treatment, people providing emergency medical care, an attorney representing you at a commitment hearing, a court, people conducting program or utilization reviews, or third-party payers (those who pay for your treatment). These people may only see as much information as they need for the specific purpose requested.
- Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.

I hereby certify that I have read and understand the Patient's Bill of Rights.

Signature:_____ **Date:** _____

HIPAA Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our notice of privacy practices is available online through WalstonHealthServices.org or at our front office.
By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available on our website or in the office.
I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- The day-to-day healthcare operations of your practice.
- I have also been informed of and given the rights to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
- I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these request restrictions.
- However, if you do agree, you are bound to comply with this restriction. I understand that I may revoke this consent at any time, in writing, signed by you.

The Client understands that:

- We will not release information to any future doctor, attorney, life insurance company, or workman's company without your written consent.
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office.
- Walston Health Services reserves the right to change the notice of privacy practices.
- The patient has the right to restrict the use of their information, but Walston Health Services does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I hereby certify that I have read and understand my rights regarding my personal health information.

Signature:_____ **Date:** _____

Limits to Privacy and Confidentiality Informed Consent to Participate in Treatment

It is important for you to know the limits to privacy and confidentiality regarding your appointments within Walston Health Services. This notice is written in accordance with departmental policy, military guidelines, and regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the final Privacy Rule of 2000. Clinics within WHS are committed to compliance with HIPAA privacy regulations.

When you speak with a mental health provider, the notes and results of your initial evaluation and subsequent visits are entered into your electronic medical record (Practice Fusion) as maintained by Walston Health Services under your social security number and will be designed as "sensitive", which offers the highest level of privacy available for this information. Access to portions of your electronic record by third parties is only allowed when required by law, regulations or judicial proceedings. This is consent with the Privacy Act Statement and the HIPAA Notice of Privacy Practice.

As a rule, your mental health provider will disclose no information obtained from your contacts with them or the fact you are receiving care in this clinic, except with your written consent. However, there are some important exceptions to this confidentiality rule as described by the following or as otherwise specified by law.

- As a general practice, we will use and disclose your protected health information to provide, coordinate, or manage your health care and related services as described in the HIPAA Notice of Privacy Practices.
- Contents of your record may also be reviewed by other healthcare providers for supervision, consultation, and quality assurance.
- If you reveal information about child neglect, abuse, or physical abuse of elders or dependent adults, we are required to report it to civil authorities.
- If you report spousal/partner abuse or drug abuse, we are required to report it to theauthorities.
- If you are judged to be suicidal or a threat to yourself, we are required to warn the intended victim and the appropriate law enforcement agencies.
- If a court of law issues a legitimate subpoena, we are required to provide the information specifically described in the subpoena.
- If you report a violation of civil law, we may be required to report it to the appropriate authorities.

Statement of Understanding and Informed Consent

I have been advised that all information obtained as herein described will be used in confidence and in conformity with Health Insurance Portability and Accountability Act (HIPAA) and/or other restrictions and protections required by law(s). As a result of the Behavioral Health evaluation, I have been informed of and recommended to participate in the specified appropriate level of treatment to include, but not limited to individual counseling or therapy, group therapy, pharmacotherapy, psychological testing, biofeedback treatment, and assessment using laboratory and/or radiological testing. I have been informed that I may refuse any or all aspects of treatment at any time, but refusing help may result in the worsening of my mental health conditions. This consent will be maintained in my medical record.

I understand that I may revoke this consent at any time and that if I do so, by signed/dated revocation, it shall be made part of my medical record.

____I consent to mental health treatment_____I do NOT consent to treatment at this time

Signature:_____ **Date:** _____

Walston Health Services
6164 Fuller Court Alexandria, VA 22310

Telepsychiatry Informed Consent

Introduction

Telepsychiatry is a form of psychiatric care using audio-video conferencing tools in which the psychiatrist and patient are not at the same location.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of health information and will include measures to safeguard the data to ensure its integrity and privacy against intentional or unintentional corruption and unauthorized access.

Expected Benefits

Benefits of telepsychiatry include improved access to psychiatry care by enabling a client to remain in his/her home or office and efficient psychiatric evaluation and management.

Possible Risks

Potential risks associated with the use of this technology include interruptions, unauthorized access, and technical difficulties.

By signing this form, I understand the following:

1. I understand that the laws that protect the privacy and the confidentiality of health information also apply to telepsychiatry and that no information obtained in the use of telepsychiatry that identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that my telepsychiatry session will not be recorded by me or my psychiatrist without both of us giving consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time, without affecting my right to future care or treatment
4. I understand that I have the right to inspect all information obtained during a telepsychiatry interaction and may receive copies of this information for a reasonable fee.
5. I understand that it is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

Client consent to the use of telepsychiatry

I have read and understand the information provided above regarding the benefits and risks of telepsychiatry. I have discussed the contents of this form with my psychiatrist, nurse, case manager, or another as may be my designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my health care.

I hereby authorize the providers at Walston Health Services to use telepsychiatry during my diagnosis and treatment.

I hereby certify that I have read and understand this Telepsychiatry Consent.

Signature:_____ **Date:** _____

Walston Health Services
6164 Fuller Court Alexandria, VA 22310

CONTROLLED MEDICATION POLICY

1. I understand I will only get controlled medication from one provider.
2. I understand that Controlled medications must be handled with care.
3. I understand that any controlled medication that is prescribed to me for my diagnosis and treatment should not be shared with friends and/or family members.
4. I understand that controlled medications should be taken according to the instructions. Dosage increasing or sudden discontinuation without the knowledge and approval of my physician is strictly forbidden.
5. I understand that early request for controlled medicine is not allowed.
6. I understand that excuses for misplaced medications such as medications that were stolen, spoiled, or somebody flushed them down the toilet are not acceptable, and in such instances, medication **Will Not BE REPLACED.**
7. I understand that Dr. Walston will monitor the proper use of my controlled medication using the Virginia Prescription Drug Monitoring system. Walston Health Services will also receive a report from my insurance company or pharmacy regarding prescription drug history or suspected prescription drug abuse. Based on this report, we may decide not to prescribe the controlled medication. We may also decide to terminate the patient-physician relationship in the interest of your safety and the best interest of the medical practice.
8. I understand that I will make Walston Health Services office staff aware at least three to five days prior to running out of my controlled medication to avoid sudden discontinuation. I understand that in order to be prescribed a controlled medication or a medication refill I may be required to schedule an appointment.
9. If I claim to be actively on treatment with suboxone with a provider and want to establish care with this practice, I will need to bring medical records from the previous provider and the latest pill bottles.

By signing this controlled substance policy, I have read, understand, and will abide by the latest terms of this contract as long as I am an active patient here at Walston Health Services.

Signature:_____ **Date:** _____

Ph: (703) 924-9810 Fax: (703) 924-7044