CLAYTOR MEMORIAL CLINIC

124 Wells Ave., NW
Roanoke, VA 24016
Phone: 540-516-5116
Fax: 877-702-6432

10401 Warwick Blvd.
Newport News, VA 23601
757-782-2643
877-702-6432

admin@claytorclinic.com
www.claytormemorialclinic.com

Authorization for Release of Information

Patient: _____ DOB: _____

I hereby authorize ___Claytor Memorial Clinic/Richard L. Claytor, Jr., MD_____
[Name and address(es) of physician, hospital, or health care provider]

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

_____

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

for the following purpose(s):_____

This information includes (check all that apply):

- ☐ Medical Records
- ☐ Educational/Academic Records
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Court Report
- ☐ Other (describe below)
- ☐ Neurological Evaluation
- ☐ Behavioral Reports
- ☐ Teacher Reports
- ☐ Treatment/Discharge Summary
- ☐ Substance Abuse Information
- ☐ Urine Screen/Breathalyzer Results

_____

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

From (date) _____ to (date or event) _____

This authorization will expire on _____ (Date or event), unless revoked by the undersigned or in one year from todays date.

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 patient 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 CMC Staff Member: _____ (Staff member name)

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Adult Psychiatric Background Information

PATIENT NAME: **DOB:** **SEX AT BIRTH: Female / Male**

PSYCHIATRIC HISTORY / INFORMATION

Briefly state the reason the patient would like to see a Psychiatrist/Psychiatric Physician Assoc. When did these symptoms begin?	

Primary Care Physician:	Facility:	Phone Number:
Previous Psychiatrist:	Facility:	Phone Number:

Is the patient presently taking prescription medications?	Yes No

If yes, please list them below:

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

Height:	Weight:	When was the patient's last medical exam?
Has the patient previously been treated by a psychiatrist? Yes No	If so, when?	Briefly describe the reason:
Has the patient previously been treated by a Therapist? Yes No	If so, when?	Briefly describe the reason:

Has the patient previously been hospitalized for psychiatric reasons? Yes No	If so, when?	Briefly describe the reason:

LEGAL HISTORY

Has the patient ever been involved with the police or juvenile court system? Yes No

If yes, please explain?

Has the patient ever had legal charges? Yes No

If yes, please explain?

FAMILY HISTORY / INFORMATION

List all persons currently residing in the patient's home:	Name:	Age:	Relationship to patient:

Does the patient have any children? Yes No
If yes please list their names below:

Name of child:	Age:	Where does the child live:

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

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Alcoholism				
Drug Abuse				
Depression				
Manic Depression				
Anxiety				
Suicide				
ADHD				
Obsessive/Compulsive Disorder				
Eating Disorder				
Other Psychiatric Disorders				
High/Low Blood Pressure				
Seizures				
Thyroid issues				
Diabetes				
Meningitis				
Heart Murmur				

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

If yes, please explain:

SCHOOL/OCCUPATION HISTORY

What is the highest level of education attained? List any degrees or certifications held:

Has the patient had any academic difficulties? Yes No
If yes, please explain:

Is the patient currently attending school? Yes No
If yes, please list name of school and program of study:

Is the patient currently employed/working? Yes No
If yes, list name of employer and occupation and length of time at current job:

Has the patient held been employed/worked in the past? Yes No
If so, list previous employers and types of work done:

SUBSTANCE ABUSE HISTORY

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	Yes	No			Yes	No
Barbiturates	Yes	No			Yes	No
Xanax, Valium, Librium	Yes	No			Yes	No
Cocaine, Crack	Yes	No			Yes	No
Heroin, Opiates	Yes	No			Yes	No
Marijuana	Yes	No			Yes	No
PCP, LSD, Mescaline	Yes	No			Yes	No
Inhalants	Yes	No			Yes	No
Caffeine	Yes	No			Yes	No
Nicotine	Yes	No			Yes	No
Amphetamines, Speed, Uppers, Crystal Meth	Yes	No			Yes	No
Designer Drugs, Ecstacy	Yes	No			Yes	No
Over-the-counter medications/supplements	Yes	No			Yes	No

Has the patient ever received substance abuse treatment? Yes No
If yes, please provide name of facility/facilities and outcome:

Cont. on next page

MEDICAL HISTORY

Has the patient ever had: Blackouts DUI Tremors Hallucinations

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

Mumps Measles Chicken Pox Seizures Asthma Heart Murmur Thyroid

High Blood Pressure Bowel or Bladder issues Diabetes Flu Chronic Pain

Please list all surgeries:

Other_____

ALLERGIES TO MEDICATIONS:

Is there anything else you would like your doctor to be aware of?

To be signed by person completing form:

_____

Print Name (Full Name)

_____ _____

Signature (Full Name) Date

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Child/Adolescent Psychiatric Background Information

NAME OF PATIENT: **DOB:** **SEX AT BIRTH: Female / Male**

PSYCHIATRIC HISTORY / INFORMATION

Briefly state the reason you would like your child to see a Psychiatrist/Psychiatric Physician Assoc. When did these symptoms begin?	

Primary Care Physician:	Facility:	Phone Number:
Other/Previous Psychiatrist:	Facility:	Phone Number:

Is your child presently taking prescription medications? Yes No

If yes, please list them below:

Current Psychiatric Medications:	Dosage:	How long has the child taken it:	Prescribing Doctor:
Previous Psychiatric Medications:			

Height:	Weight:	When was your child's last medical exam?
Has your child previously been treated by a psychiatrist? Yes No	If so, when?	Briefly describe the reason:
Has your child previously been treated by a Therapist? Yes No	If so, when?	Briefly describe the reason:

Has your child previously been hospitalized for psychiatric reasons? Yes No	If so, when?	Briefly describe the reason:

LEGAL HISTORY

Has your child been involved with the police or juvenile court system? Yes No

If yes, please explain?

Has your child ever had legal charges? Yes No

If yes, please explain?

FAMILY HISTORY / INFORMATION

Father's Name:	Living	Occupation:	Age:
	Deceased	Cause of Death:	Age at time of Death:
Mother's Name:	Living	Occupation:	Age:
	Deceased	Cause of Death:	Age at time of Death:

Are the child's parents divorced or separated? Yes No If yes, what age was the child when they separated/divorced?

Was your child adopted? Yes No

If yes, at what age:

If yes, does the child know? Yes No

List any siblings and their ages:	Name:	Age:	Relationship (biological, half, step, adopted, foster):

List all current members of the child's household:

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

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Alcoholism				
Drug Abuse				
Depression				
Manic Depression				
Anxiety				
Suicide				
ADHD				
Obsessive/Compulsive Disorder				
Eating Disorder				
Other Psychiatric Disorders				
High/Low Blood Pressure				
Seizures				

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Thyroid issues				
Diabetes				
Meningitis				
Heart Murmur				

Does your child have a history of physical, verbal, or sexual abuse? Yes No

If yes, please explain:

DEVELPOMENTAL HISTORY

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

If yes, please explain:

Did the mother suffer from any illnesses during pregnancy? Yes No

If yes please explain:

Please check any substances that were used during pregnancy:

Tobacco Alcohol Illegal Drugs Prescription Medications Other

If any are checked, please explain:

Was the pregnancy full term? Yes No If no what were # of weeks at delivery?

Mother's age at the time of birth: Father's age at the time of birth:

Type of delivery: Normal Cesarean Breach

At what age did your child:

Walk alone: Use single words: Form sentences: Toilet train:

Has your child ever had an eye and/or hearing exam? Yes No

If yes, when and what were the results?

Has your child experienced a loss of consciousness? Yes No

If yes, please explain:

Has your child experienced a head injury? Yes No

If yes, please explain:

Self help skills: Average Slow Poor
(dressing, brushing, toileting, hygiene)

Has your child ever been separated from either parent? Yes No

If yes, please explain:

If yes, what age?

SCHOOL HISTORY

School Currently Attending: Grade:

Previous Schools Attended: Grades:

Grades:

School Attendance Record: Excellent Good Poor

Has your child had any problems academically? Yes No

If yes, please explain:

Has your child repeated or skipped any grades? Yes No

If yes, please explain:

Has your child experienced any social problems at school? Yes No

If yes, please explain:

Has your child been in detention or suspended? Yes No

If yes, please explain:

Has your child been expelled? Yes No

If yes, please explain:

Has your child experienced any traumatic experiences related to school? Yes No

If yes, please explain:

Has your child had psychological testing? Yes No

If yes, please explain:

Has your child ever had special education services or known learning disabilities? Yes No

If yes, please explain:

Does your child currently have an IEP? Yes No

If yes, please explain:

What does your child do best in school?

SUBSTANCE ABUSE HISTORY

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	Yes	No			Yes	No
Barbiturates	Yes	No			Yes	No
Xanax, Valium, Librium	Yes	No			Yes	No
Cocaine, Crack	Yes	No			Yes	No
Heroin, Opiates	Yes	No			Yes	No
Marijuana	Yes	No			Yes	No
PCP, LSD, Mescaline	Yes	No			Yes	No
Inhalants	Yes	No			Yes	No
Caffeine	Yes	No			Yes	No
Nicotine	Yes	No			Yes	No
Amphetamines, Speed, Uppers, Crystal Meth	Yes	No			Yes	No
Designer Drugs, Ecstacy	Yes	No			Yes	No
Over-the-counter medications/supplements	Yes	No			Yes	No

Has your child ever received substance abuse treatment? Yes No

MEDICAL HISTORY

Has your child ever had Blackouts DUI Tremors Hallucinations

Please circle all that apply to your child and list any additional medical history:
Mumps Measles Chicken Pox Seizures Asthma Heart Murmur Thyroid
High Blood Pressure Bowel or Bladder issues Diabetes Surgery Flu
Other_____

ALLERGIES TO MEDICATIONS:

Is there anything you would like to tell us about your child?

REPORT OF CURRENT AND PAST SYMPTOMS

Please check any problems that your child either has had in the past or is currently having.

Current	Past		Current	Past	
		Obsess about checking, counting/ or washing hands			Hear voices
		Feel people are after you, against you, following you			Unusual thinking
		Odd speech/thinking			Not interested in making friends
		Fear of becoming fat			Engage in self-induced vomiting
		Gorging on food			Excessive dieting/exercise
		Use laxatives			Eat things that are not food
		Shy			Expect failure
		Selfish			Lazy
		Avoid Adults			Easy Going
		Friendly			Enthusiastic
		Slow moving			Easily embarrassed
		Few close friends			Lack of responsiveness to others

		Messy			Careless, reckless
		Learning difficulties			Difficulty paying attention

Current	Past		Current	Past	
		Disorganized			Fidgety, restless, overactive
		Talking/acting without thinking			Short attention span
		Frequent daydreams			Self-mutilation
		Bored easily			Vandalism
		Fire-setting			Nightmares
		Afraid to leave a loved one			Fear of strangers
		Often sick on school/work days			Refusing to talk
		Defiant of authority			Often disobedient
		Argumentative			Upset of minor changes
		Stubborn			Temper tantrums/ Sudden anger
		Lack of guilt over wrong doing			Bullies others
		Sexually acting out			Lying
		Truancy			Physically aggressive toward others
		Theft			Lack self-confidence
		Problems with long-term memory			Problems with short-term memory

To be signed by person completing form:

Print Name (Full Name) _____ Relationship to Child _____

Signature (Full Name) _____ Date _____

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Outpatient Referral Form

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DATE OF REFERRAL:	

SERVICE DESIRED:		Psychiatric Services

Chief Complaint/ Presenting Problem:	

PATIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION			
Name:			
Address:			
Home Phone:		Date of Birth:	
Cell Phone:		Gender at birth:	
Work Phone:		Race:	
Social Security Number:		Marital Status:	

INSURANCE INFORMATION:	
Medicaid MCO & ID Number:	
Private Insurance Name and Phone Number	
Private Insurance Behavioral Health Name and Phone Number	
Private Insurance ID and Group Number	
Private Insurance Policy Holders Name and SSN	

DIAGNOSTIC INFORMATION:	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION (If Applicable)					
Name:				Relationship:	
Address:					
Home Phone:		Cell Phone:		Work Phone:	

EMERGENCY CONTACT INFORMATION					
Name:				Relationship:	
Address					
Home Phone:		Cell Phone:		Work Phone:	

	CURRENT SERVICE PROVIDERS:	
	MHSS PROVIDER:	
	PSYCHIATRIST:	
	OUTPATIENT COUNSELOR:	
	OTHERS:	

REFERRING PARTY NAME:		REFERRING AGENCY:	
MAILING ADDRESS:			
TELEPHONE NUMBER:		E-MAIL ADDRESS:	
FAX NUMBER:			

Please fax referral form to Claytor Memorial Clinic at 877-702-6432

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Outpatient Service Authorization and Permission to Treat

Patient's Name: (first, middle, last) _____

SSN _____ DOB: _____ Race: _____ Gender: M F

Marital Status: (circle one) Single Married Divorced Separated

Current Residence: (street, city, state, zip) _____

Home phone: _____ Cell phone: _____ Work phone: _____

May we leave a message at the telephone numbers listed above? (circle one) **Yes** **No**

Email address for reminders: _____

Parent/Guardian Name: _____ Relationship: _____

Address if not the same: _____

12 digit Virginia Medicaid:#: _____ Copay$_____
Circle one: Medicaid, Va Premier, Optima, Aetna, United Healthcare, Anthem, Molina ***Private/other:_____ ***Fill in below

Primary Private Insurance Co: _____ Customer Service Phone: _____
Mental/Behavioral Health Carrier:_____ Phone:_____
Policy Holder's Name::_____Relationship:_____
Policy Holder SSN :_____ Policy Holder's Date of Birth:_____

Address of Policy Holder (if different):_____
Insurance Claims Address:_____
Policy/ID#:_____ Group #:_____ Copay/CoInsurance $_____
Deductible info: _____
Prior Authorization info:_____

Secondary Private Insurance Co: _____ Customer Service Phone: _____
Mental/Behavioral Health Carrier:_____ Phone:_____
Policy Holder's Name::_____Relationship:_____
Policy Holder SSN :_____ Policy Holder's Date of Birth:_____

Address of Policy Holder (if different):_____
Insurance Claims Address:_____

Policy/ID#:_____ Group #:_____ Copay/Coinsurance $_____
Deductible info: _____
Prior Authorization info: _____

By signing below:

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

Parental/guardian/authorized representative signature gives Claytor Memorial Clinic permission to treat myself/ the person listed above/my child and obtain emergency medical care while in our office.

_____ _____
Parent/guardian/authorized rep/foster parent/SW Date CMC Staff Signature

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Missed Appointment and Late Cancellation Policy

Claytor Memorial Clinic reserves appointment times specifically for each patient. Appointments must be canceled or rescheduled at least 24 hours before the scheduled appointment time.

Commercial Insurance and Self-Pay Patients

An appointment that is missed, or canceled or rescheduled with less than 24 hours' notice, may result in a $50 fee charged to the patient's account.

This fee is the responsibility of the patient or responsible party and will not be submitted to insurance. Non-urgent future appointments may not be scheduled until the fee has been paid or other arrangements have been approved by the Clinic.

Repeated missed appointments or late cancellations may result in discharge from the practice following appropriate notice and continuity-of-care procedures.

Medicaid and FAMIS Patients

Medicaid and FAMIS patients will not be charged a missed-appointment fee.

However, missed appointments and appointments canceled or rescheduled with less than 24 hours' notice will count toward the Clinic's attendance policy.

More than one missed appointments or late cancellations may result in:

1. A written reminder of the attendance policy.
2. A formal attendance warning.
3. Review for possible discharge from the practice.

The Clinic may consider emergencies, hospitalizations, transportation failures, placement disruptions, family crises, or other documented extenuating circumstances.

Discharge decisions will be based on more than one failure to attend scheduled appointments and the Clinic's resulting inability to provide safe, consistent, and clinically appropriate treatment—not on a patient's insurance status or inability to pay a fee.

Urgent clinical concerns, medication safety issues, and necessary transition care will be addressed according to clinical judgment.

Acknowledgment

By signing below, I acknowledge that I have read and understand Claytor Memorial Clinic's Missed Appointment and Late Cancellation Policy. I understand that repeated missed appointments or late cancellations may affect the Clinic's ability to continue providing services.

Patient Name: _____

Responsible Party: _____

Signature: _____

Date: _____

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1. Office Hours: (*subject to change)*
Monday – Thursday from 8:00 AM - 5:00 PM (Clinic open for appointments and all other services)

2. Physician and Physician Assistants:
Richard Claytor, Jr., MD
Heather Martin, PA-C

3. Practice Parameters:
This practice is **strictly outpatient.** The Physician and the Physician Associates/Nurse Practitioners see patients during regular business hours only. Calls placed to the office outside of regular business hours will be returned within 2 business days. *In addition to medication management services, our providers **strongly** recommend additional supportive services and counseling for patients.* A list (by no means complete) of agencies to choose from is available.

4. Appointments:
Patients 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 5 PM the Thursday beforehand. **LESS THAN 24 HOURS' NOTICE = NO-SHOW. 2 NO-SHOWS = DISCHARGE**. **THERE IS A $50 FEE FOR NO-SHOW**. Your providers will make every effort to be on time as well however ask for your understanding and patience as emergent situations may arise causing an appointment to exceed the allotted time.

Cancellations on the day of an appointment or arrival 10 minutes late are considered missed appointments. **We will be unable to reschedule patients who miss their initial evaluation.**

5. Medication Refills:
Keeping scheduled appointments is important to maintaining your treatment and prescriptions. Should you miss an appointment, **ONLY ENOUGH MEDICATION WILL BE PROVIDED UNTIL OUR NEXT AVAILABLE APPOINTMENT. IF YOU ARE NOT SEEN WITHIN THAT TIMEFRAME, YOUR MEDICATION 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 prescriptions will not be refilled automatically.

6. Initial Assessment:
Initial assessments are conducted by the psychiatrist and physician associate to:

- Gather data by which the psychiatrist and treatment team 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;
- 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. Inclement Weather:
Inclement weather notifications are posted on the office's voicemail as well as the local news. Please call (540) 516-5116 after 7:15 a.m. or check your local news for weather related information.

8. 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. Instead, we ask that you call:

Emergency Services: **911**

Respond: (540) 776-1100 or (800) 541-9992
Connect: (540) 981-8181 or (800) 284-8898

9. 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. 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 every reasonable effort to limit PHI disclosure to the minimum necessary required to accomplish the intended purpose of the use, disclosure or request.

11. Release of Medical Records/Filling out Forms (Homebound, FMLA, etc):

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.

THERE IS A $15 FEE TO FILL OUT ANY FORMS, PAPERWORK, HOMEBOUND, DMV, FMLA, ETC. LIMITED CHANGE IS AVAILABLE!

12. 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 either parent having legal, including joint 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. 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.

CMC 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. Making a Complaint or Filing a Grievance
To all patients of Claytor Memorial Clinic:

If you are dissatisfied with the services being provided by CMC 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 CMC staff providing the service.
2. If the conflict is not resolved, or if you do not feel comfortable making the complaint to the CMC staff member, request the name and method of contacting the supervisor of the CMC staff member.
3. If conference with the immediate supervisor does not end in a satisfactory resolution, if you are still dissatisfied after talking with the person in the supervisor's office, you may contact the DMHMRSAS 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 supervisor's 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 supervisor's office.

Supervisor's Office: **Richard L. Claytor, Jr., MD**
124 Wells Ave., NW
Roanoke, VA 24016
Phone: 540-516-5116
Fax: 877-702-6432

Regional Contact Information:

- **Mandy Crowder** (Region 3 Regional Human Rights Manager):
  - **Phone:** 434-713-1621 or toll-free 833-425-7159
  - **Email:** mandy.crowder@dbhds.virginia.gov

- **Mykala Sauls** (Human Rights Advocate for the Roanoke area/Catawba Hospital):
  - **Phone:** 434-773-4315 or cell 804-931-0505
  - **Email:** mykala.sauls@dbhds@virginia.gov
  - **Primary Office Location:** **C**atawba Hospital, 5525 Catawba Hospital Dr., Catawba, VA 24070

15. Patient Rights

As a patient of this program, you have certain rights, which are set out in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation, and Substance Abuse 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

Claytor Memorial Clinic 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 Director, 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 patients, 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 Regional Manager or Medical Director. In answering your complaints, CMC 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 patients and to make programs recognize patient 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 CMC staff will help you to make the contact.

Statement of Understanding

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

1. Office Hours:
2. Physician
3. Practice Parameters:
4. Appointments
5. Medication Refills
6. Initial Assessment
7. Inclement Weather
8. Emergency Procedures
9. Protection of Medical Information (HIPAA):
10. Patient Rights to Access Medical Information:
11. Release of Medical Records:
12. Permission to Treat a Minor Child
13. Billing and Insurance
14. Making a Complaint or Filing a Grievance
14. Patient Rights

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

_____
Signature Date