



RICE CLINIC

*eternal values for the body, mind & soul*

Dear Friend:

We are grateful you have selected the Rice Clinic for your healthcare needs and look forward to meeting with you.

ROBERT RICE, M.D.  
C. BRENT LAWLIS, M.D.  
ABEER WASHINGTON, M.D.  
SONYA CANFIELD,  
APRN, PMHNP-BC

Visits are by appointment only and appointment times vary according to individual therapists or psychiatrists. Office staff is available from 7:30 a.m. to 4:30 p.m. Monday through Thursday to answer your call. In the event of an emergency your call will be answered by our answering service and one of our professionals will get back with you as soon as possible.

SUSAN BRYANT, Ph.D.  
MARGARET COLE, L.P.E-I  
DOUG DAMRON, M.S., L.P.C.  
STEPHANIE HARRINGTON,  
Ph.D., L.C.S.W.

Please feel free to contact us anytime during office hours if you have any questions or need additional information or visit our website at [www.rice-clinic.com](http://www.rice-clinic.com). Services that are not rendered by the Rice Clinic include any treatment, evaluation or diagnosis of a disability, or treatment or evaluation involving pending or anticipated court cases including, without limitation, custody, divorce or employment matters.

KANDI HOLMES, L.P.E-I  
MAURINE RICHARDSON, L.C.S.W.  
SCOTTY SMITTLE, L.P.C.

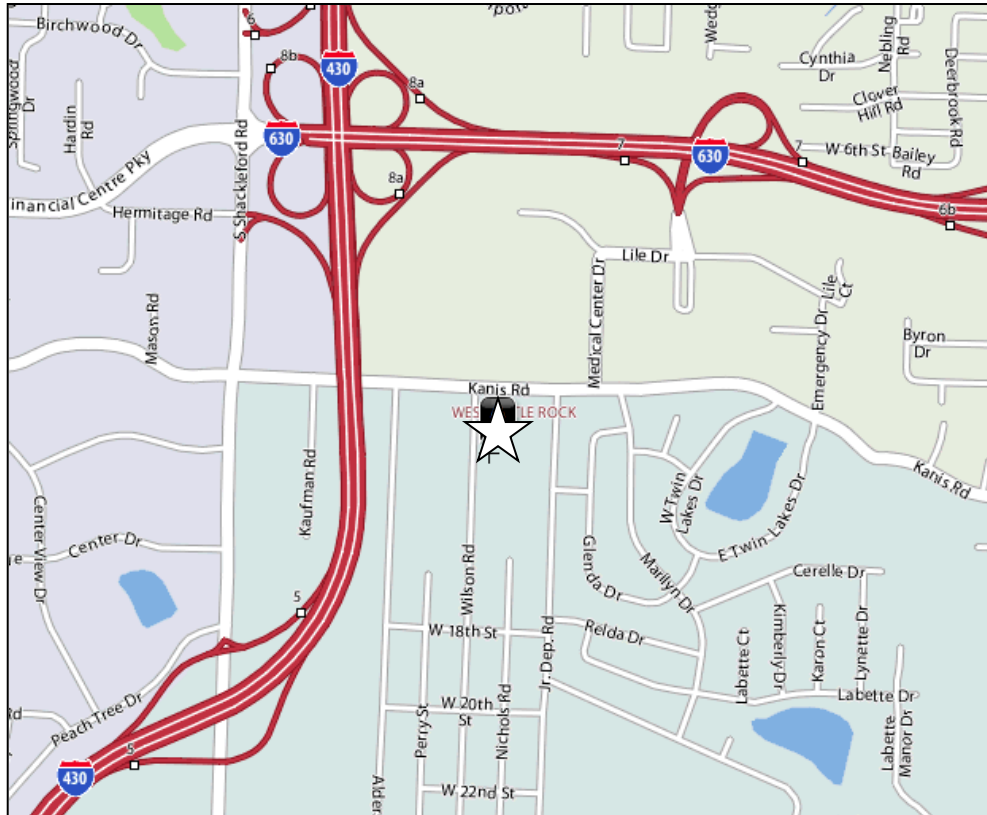
An advance cancellation notice of 24 hours is required on all therapy appointments. Same day cancellations are considered a late cancellation and will be subject to the late cancellation fee of \$25.00. If a patient does not show up for a scheduled appointment the fee is \$50.00.

Enclosed you will find your new patient forms. Please complete these forms in their entirety and bring them with you to your appointment. If your forms are not completed by your scheduled appointment time, we will need to reschedule your appointment. Please arrive for your appointment 20 minutes early to finish the new patient registration process.

Thank you for choosing us as your healthcare providers. We look forward to serving you.

Sincerely,

Robert L. Rice, M.D. and Staff



 **Rice Clinic**  
**1301 Wilson Road**  
**Little Rock, AR 72205**

**From I-430**

Take the Shackleford Exit (#5), go north to Kanis Road and turn right. On Kanis, go over the overpass and then turn right on the second road which is Wilson. The Clinic is on the left at 1301 Wilson Road.

**From I-630**

Follow I-630 West to the stoplight at Shackleford and I-630. Turn left on Shackleford. Go to the second light and turn left on Kanis. On Kanis, go over the overpass and then turn right on the second road which is Wilson. The Clinic is on the left at 1301 Wilson.

# The Rice Clinic

## New Patient Registration

Patient Name \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
City/State/Zip Code \_\_\_\_\_  
Primary Phone # \_\_\_\_\_  Single  Married  Widow  Divorced  
Social Security # \_\_\_\_\_ Patient Employer \_\_\_\_\_ Title \_\_\_\_\_  
Employer's Address/Phone # \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Address (if different) \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Primary Care Doctor: \_\_\_\_\_ Primary Care Doctor Phone: \_\_\_\_\_

### Guarantor of Account

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Ph # \_\_\_\_\_  
Address \_\_\_\_\_  
Employer \_\_\_\_\_ Work Ph # \_\_\_\_\_

### Insurance

Primary Insurance Carrier \_\_\_\_\_ Phone # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Patient Relationship \_\_\_\_\_  
Insurance I.D.# \_\_\_\_\_ Group Name/ # \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_  
Secondary Insurance Carrier \_\_\_\_\_ Phone # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Patient Relationship \_\_\_\_\_  
Insurance I.D.# \_\_\_\_\_ Group Name/ # \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

### Referral Source Information

I chose the clinic because:  Family/friend referral  Dr. Referral (Name \_\_\_\_\_ )  
 Radio (station \_\_\_\_\_ )  Heard Dr./Therapist Speak  
 Newspaper  Other \_\_\_\_\_

### Financial Issues

The fee for each session will be due on the date of service. Cash, personal checks and most major credit cards are acceptable for payment. We will notify you in advance if clinic fees should change for the services you are receiving. You will need to make a decision in regard to paying for services. If you have health insurance you will need to decide if you want to file charges with your health insurance or if you would prefer to pay out of pocket. A benefit of using health insurance is financial reimbursement for services (payment will vary depending on your insurance). Qualifying psychiatric diagnoses if appropriate will be used when filing with your insurance company.

**Please sign below** as an agreement that you have read, understand and will accept the terms of your financial responsibility.

Signature \_\_\_\_\_ Date \_\_\_\_\_

In case of an emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize the Rice Clinic to release medical information to insurance carriers concerning the illness/accident and to make any necessary appeals on my behalf. I assign claim payments to the Rice Clinic if they file a claim on my behalf for services provided. This authorization and assignment may be revoked by me at any time by written notice.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Signed by \_\_\_\_\_ Relationship \_\_\_\_\_

# LIFE HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

Please give brief explanation and history:

1. Present problem – list 3 main problems (anxiety, depression, etc.) and what caused it.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Symptoms: (please circle all that apply)

A. Change in sleep pattern

E. Decreased concentration

B. Change in appetite

F. Increased anxiety

C. Decreased energy

G. Suicidal feelings

D. Decreased motivation

H. Other (please list) \_\_\_\_\_

\_\_\_\_\_

3. Childhood including first 15 years – please circle one: (traumatic, uneventful). List 2 – 3 traumatic events in the first 15 years. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Father – What was he like? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Mother – What was she like? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Brothers and/or Sisters – What type of relationship did you have with them? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. School history – including what type of grades you made and how far you went. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Marriages – How many and what type of stresses in the marriage? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OVER**

9. Children – How many, including ages? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Psychiatric history – including any previous counseling and medications. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Drug Allergies. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Medical – condition of health, any medical problems. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Current interests - (Family, church, friends, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Job History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Religious history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SYMPTOM CHECK LIST

Name \_\_\_\_\_

Please read and make a check in one of the columns for each item. Decide the extent to which each item describes the way you feel or behave, or the problems you may be having.

	within the last week	within the last 6 months	infrequently or never
difficulty sleeping	_____	_____	_____
poor physical condition	_____	_____	_____
anxious and tense	_____	_____	_____
disturbing thoughts	_____	_____	_____
unable to sit still	_____	_____	_____
sad, discouraged	_____	_____	_____
feel like killing myself	_____	_____	_____
people don't understand me	_____	_____	_____
family problems	_____	_____	_____
poor social life	_____	_____	_____
quick to anger	_____	_____	_____
physical violence	_____	_____	_____
in trouble with the law	_____	_____	_____
drinking more than usual	_____	_____	_____
strange or puzzling things happening to me	_____	_____	_____
seeing visions	_____	_____	_____
hearing things that others can't hear	_____	_____	_____
can't get things done	_____	_____	_____
sexual conflicts	_____	_____	_____
nightmares	_____	_____	_____
headaches or stomach aches	_____	_____	_____
religious conflicts	_____	_____	_____
overwhelming guilt feelings	_____	_____	_____
heavy use of medications	_____	_____	_____
change in eating habits	_____	_____	_____

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

If this questionnaire is completed by an informant, what is your relationship with the individual? \_\_\_\_\_

In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_ hours/week

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	





**RICE CLINIC**  
**Consent to Specific Forms of Communication**

**\*If you choose text or e-mail, your information may not be secure as the information will not be encrypted.**

I authorize contact from this office to **confirm my appointments, treatment and billing information via:**

Cell Phone     Home Phone     Work Phone     Email     Text to Cell Phone     Any of the Above

I authorize **information about my health** be provided to me via:

Cell Phone     Home Phone     Work Phone     Email     Text to Cell Phone     Any of the Above

I approve being contacted about **special services, events, fund raising efforts or new health information** on behalf of this healthcare facility via:

Cell Phone     Home Phone     Work Phone     Email     Text to Cell Phone     Any of the Above

\_\_\_\_\_  
Please **Print** Patient's name                      Date                      Please **Sign** your name

\_\_\_\_\_  
Legal Representative                      Date                      Description of Authority

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PATIENT'S DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**RICE CLINIC**  
**Limits of Confidentiality**

I understand that, although information obtained from or divulged by me is treated in strict confidence and ordinarily will not be transmitted to another person or agency without my prior consent, the Rice Clinic is obligated by law and may divulge, at the discretion of the professional staff and not necessarily with consent, information about me to another party if I indicate, by word or in action, that:

- 1) I am abusing a child or have abused a child in the past,
- 2) I am a minor child who has been the victim of child abuse or physical or sexual assault or neglect
- 3) I am an elderly adult who has been abused or neglected by a caretaker
- 4) I intend to physically harm another person
- 5) I intend to physically harm myself; or
- 6) I am unable to provide for my physical safety.

I understand that the professional staff may contact any third parties that is/are deemed necessary in order to protect my physical safety or that of another person. Furthermore, I understand that my records from the Rice Clinic are subject to subpoena. I understand that should a Court subpoena all of, or any portion of, my records from the Rice Clinic, the Clinic may submit its records to the Court. Otherwise, the Clinic will consider all information provided as privileged confidential information, and except as noted in the situations above, will not release any information about me or my records to any individual or agency without obtaining my prior approval in the form of a signed authorization.

I have read the above and understand its contents.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature (if child is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## **FEES FOR MISSED APPOINTMENTS\***

A scheduled appointment is time reserved for your exclusive use. It remains your financial responsibility unless you release it for use by someone else by canceling no later than 8:00 am on the day of service, which allows the Rice Clinic to offer the time to another client. Missed appointments and late cancellations have the potential to be troublesome and to be a challenge to the therapeutic relationship. Therefore, our policy concerning missed appointments is adhered to without exception.

- **Missed Appointments** (not kept or not cancelled) → **\$35** automatically charged by the Rice Clinic regardless of the reason (e.g., illness, emergency, or inclement weather)
- **Late Cancellations** (cancelled after 8:00 am on day of service) → **\$25** charge

Appointments may be cancelled by fax (501-224-5625), voicemail (501-225-0576), or by speaking to someone at the Rice Clinic. If you leave a voicemail cancellation prior to business hours, it is important that you ensure the cancellation by calling the Rice Clinic and speaking to a receptionist. Monday appointments must be cancelled no later than 8:00 am Monday.

Insurance companies will not pay for missed appointment fees or late cancellation fees.

Fee tickets for missed appointments say "Missed Appointment". To do otherwise may defraud insurers. Fees charged for missed appointments are due immediately and future appointments can be reserved only if payment arrangements are made immediately following the missed appointment. Payment may be made by mailing a check or by calling with credit/debit card information.

I have read and understand this policy regarding missed appointments.

---

Signature/Date

---

Rice Clinic Witness Signature/Date

*\*Policy effective 3/23/2009*

Robert L. Rice, M.D.  
Psychiatrist

C. Brent Lawlis, M.D.  
Psychiatrist



Sonya Canfield, APRN  
PMHNP-BC

Abeer Washington, M.D.  
Psychiatrist

## CONTRACT FOR PATIENTS USING CONTROLLED SUBSTANCES

Sedative hypnotics, benzodiazepines, wake-promoting agents, and stimulants may be useful in treating your clinical disorder, but because of the high potential for misuse and abuse they are closely controlled by state and federal governments. The drugs are intended for therapeutic purposes and to improve functioning, not to provide a feeling of euphoria.

This is a contract between \_\_\_\_\_ (patient) and \_\_\_\_\_ (provider).

The prescribing provider and only this provider will provide:

Sedative hypnotics     Benzodiazepines     Stimulants for the patient (controlled substances).

In addition, as a patient I agree that:

1. All prescription renewals for controlled substances must be anticipated and requested during REGULAR OFFICE HOURS.
2. Refills will not be made if I “run out early” for any reason.
3. All prescriptions for controlled substances will be filled at only (1) pharmacy.
4. Should theft or loss of the controlled substances occur, the local police must be notified and a copy of the OFFICIAL police report be brought to the office, which MUST include the officer’s printed name, badge number, and telephone number of the police department making the report. Only then will the provider consider the patient’s request for a prescription renewal. Replacement is not guaranteed and is at the discretion of the prescribing provider.
5. By signing this agreement, I am giving informed consent to controlled substance maintenance therapy and understand clearly that:
  - A. There is a low but definite risk of becoming dependent on the drug(s).
  - B. There is potential for impaired thinking with the drug alone, but especially when used with other controlled substances and alcohol.
  - C. With evidence of drug seeking behavior outside of this agreement, the provider may discontinue my medical care.
  - D. The doctor has my permission to order blood or urine studies for drug levels as he/she sees need.
  - E. This contract may be sent to my family physician, other physicians participating in my care, dentists, and my pharmacists.
  - F. I give permission for my pharmacist(s) to release any information about prescription drugs I am taking or have taken.

PATIENT’S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_