RICE CLINIC

eternal values for the body, mind & soul

ROBERT RICE, M.D.

ABEER WASHINGTON, M.D.

C. BRENT LAWLIS, M.D.

SONYA CANFIELD, APRN, PMHNP-BC

KEVIN ROWELL, Ph.D.

SUSAN BRYANT, Ph.D.

DOUG DAMRON, M.S., L.P.C.

RON MCCAFFERTY,M.S., L.C.S.W.

STEPHANIE HARRINGTON, Ph.D., L.C.S.W.

MAURINE RICHARDSON, L.C.S.W.

KANDI HOLMES, M.S., LPE-I

MARGARET COLE, M.S., LPE-I

R. SCOTTY SMITTLE, M.S., L.P.C.

Dear Friend:

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

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.

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. 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.

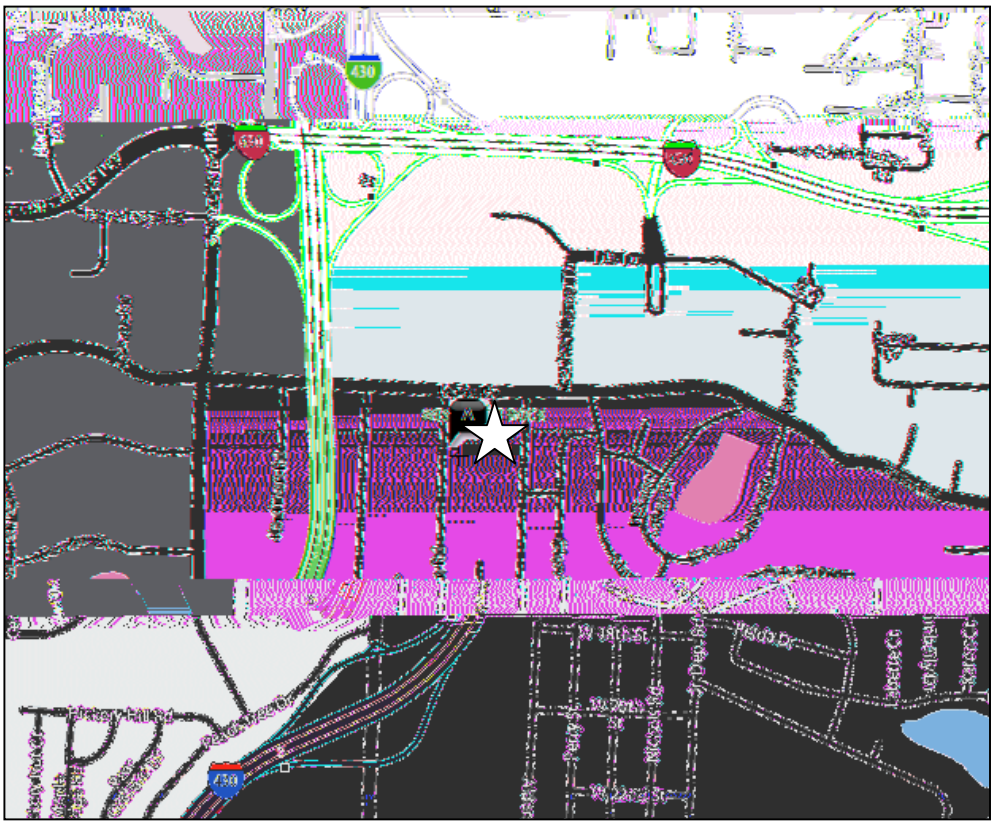
An advance cancellation notice of 24 hours is required on all therapy appointments. Same day cancellations are considered a late cancellation and will be subject to the late cancellation fee of $25.00. If a patient does not show up for a scheduled appointment the fee is $50.00

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
   B. Change in appetite
   C. Decreased energy
   D. Decreased motivation
   E. Decreased concentration
   F. Increased anxiety
   G. Suicidal feelings
   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 **TWO (2) WEEKS**, 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.	. Little interest or pleasure in doing things?	0					
	. Feeling down, depressed, or hopeless?	0					
II.	. Feeling more irritated, grouchy, or angry than usual?	0					
III.	. Sleeping less than usual, but still have a lot of energy?	0					
	. Starting lots more projects than usual or doing more risky things than usual?	0					
IV.	. Feeling nervous, anxious, frightened, worried, or on edge?	0					
	. Feeling panic or being frightened?	0					
	. Avoiding situations that make you anxious?	0					
V.	. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0					
	0. Feeling that your illnesses are not being taken seriously enough?	0					
VI.	. Thoughts of actually hurting yourself?	0					
VII.	. Hearing things other people couldn't hear, such as voices even when no one was around?	0					
	. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0					
VIII.	. Problems with sleep that affected your sleep quality over all?	0					
IX.	. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0					
X.	. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0					
	. Feeling driven to perform certain behaviors or mental acts over and over again?	0					
XI.	. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0					
XII.	. Not knowing who you really are or what you want out of life?	0					
	0. Not feeling close to other people or enjoying your relationships with them?	0					
XIII.	. Drinking at least drinks of any kind of alcohol in a single day?	0					
	. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0					
	. 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					

CURRENT MEDICATIONS

Patient Name:	**Date of Birth:**

Please list all prescription and over the counter medications, herbals, vitamins, minerals, and dietary (nutritional) supplements.

Name	**Dosage**	**Frequency**	**By mouth, shot, patch, etc.**	**Reason**	**Doctor**

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

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. Multiple missed appointments and late cancellations may result in dismissal from the clinic.

- **Missed Appointments** (not kept or not cancelled) → **$50** 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 4/13/2017

Robert L. Rice, M.D.
Psychiatrist

Abeer Washington, M.D.
Psychiatrist

C. Brent Lawlis
Psychiatrist

Sonya K. Canfield, A.P.R.N.
PMHNP-BC

RICE CLINIC

eternal values for the body, mind & soul

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. We participate in the Arkansas Prescription Drug Monitoring Program with the goal of enhancing patient care and ensuring legitimate use of controlled substances.

This is a contract between _____ (patient) and _____(provider).

The prescribing provider and only this provider will provide controlled substances including but not limited to Sedative hypnotics, Benzodiazepines, and 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 _____