RICE CLINIC

eternal values for the body, mind & soul

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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.

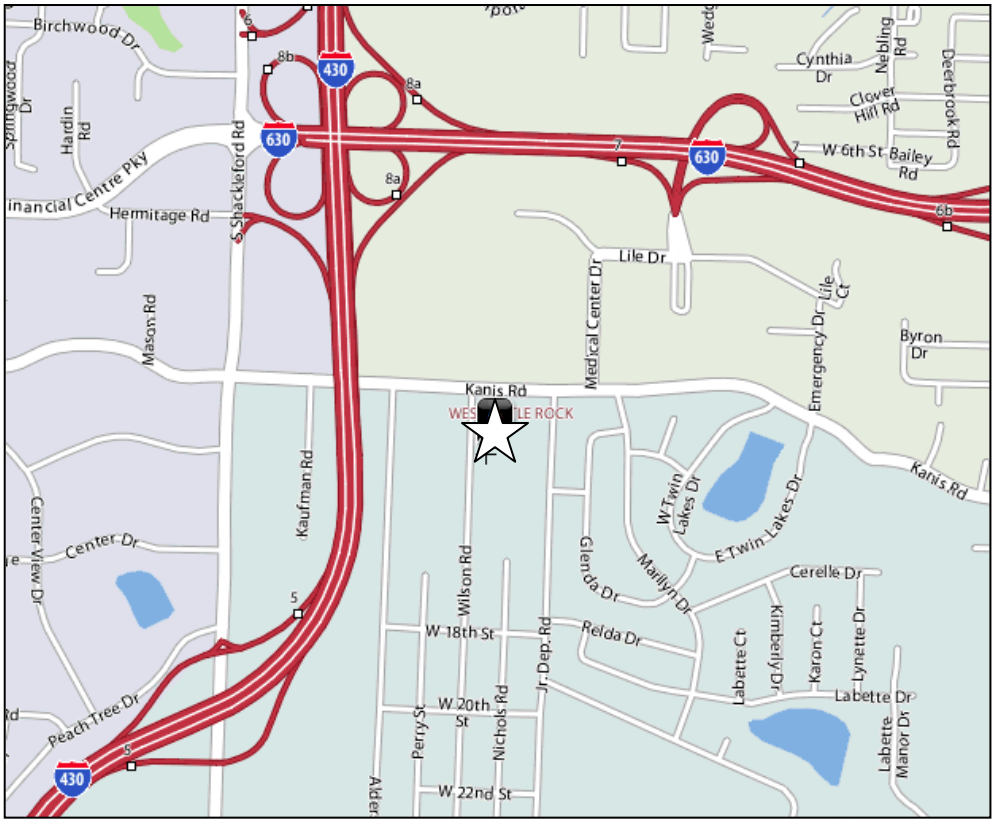
An advance cancellation notice of 24 hours is required on all therapy appointments. Same day cancellations are considered a late cancellation and will be subject to the late cancellation fee of $25.00. If a patient does not show up for a scheduled appointment the fee is $35.00.

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.

RICE CLINIC
CHILD & ADOLESCENT REGISTRATION

Child's Name_____ Date of Birth: _____ Age: _____

Parent's Name: _____ Soc. Sec. #: _____

Street Address:_____ Home Phone: _____

City/State/Zip: _____

Parent's Workplace: _____ Work or Cell Phone: _____

Emergency Contact (not parent): _____

Relationship to Child: _____ Phone: _____

Pediatrician/PCP: _____ Pediatrician/PCP Phone: _____

Guarantor of Account: _____ SSN: _____

DOB of Guarantor: _____ Check if address same as above _____

Address (if different): _____

Employer (if different): _____ Phone: _____

Insurance Information

Primary Insurance Carrier: _____ Phone: _____

Subscriber's Name: _____ Relation to Child: _____

Subscriber's Date of Birth: _____ SSN: _____

Insurance ID#: _____ Group Name/No: _____

Secondary Insurance Carrier: _____ Phone: _____

Subscriber's Name: _____ Relation to Child: _____

Subscriber's Date of Birth: _____ SSN: _____

Insurance ID#: _____ Group Name/No: _____

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT unless cancelled twenty-four (24) hours in advance.

IN CASE OF DIVORCE: The parent who authorized the child to receive treatment is responsible for payment.

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

Patient: _____ Date: _____ Signature: _____ Relationship: _____

PERMISSION FOR TREATMENT: I give permission to the Rice Clinic to treat the above registered minor.

ACKNOWLEDGEMENT: I acknowledge that I am not to leave my minor child at the clinic unattended by parent, guardian, or responsible adult and that the Rice Clinic is not responsible for watching after my minor child either before the appointment or after the appointment.

Signature: _____ Date: _____ Relationship: _____

I give my permission for my child (who is a licensed driver) to drive to and from the clinic for appointments.

Signature: _____ Date: _____ Relationship: _____

Child Symptom Checklist – IV

Child: _____ Date: _____

Age: _____ Rater: _____

Instructions: Check (✓) which rating best describes the child's overall behavior. Answer each question to the best of your ability.

Section 1a	**Never**	**Some-times**	**Often**	**Very Often**
1. Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.				
2. Has difficulty maintaining attention in tasks or play activities.				
3. Does no seem to listen when spoken to directly.				
4. Does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions).				
5. Has difficulty organizing tasks and activities.				
6. Avoids, dislikes, or is reluctant to engage in tasks that require continued mental effort) such as schoolwork or homework)				
7. Loses things necessary for tasks or activities (for example, toys, school assignments, pencils, books, or tools).				
8. Is easily distracted by other things going on.				
9. Is forgetful in daily activities.				

Section 1b

1. Fidgets with hands or feet or squirms in seat.				
2. Leaves seat in classroom or in other situations in which remaining in seat is expected.				
3. Runs about or climbs too much in situations in which it is inappropriate.				
4. Has difficulty playing quietly.				
5. Is "on the go" or acts as if "driven by a motor".				
6. Talks too much.				
7. Blurts out answers before questions have been completed.				
8. Has difficulty awaiting turn.				
9. Interrupts or intrudes on others (for example, butts into conversations or games).				

Section 2

	Never	Some-times	Often	Very Often
1. Loses temper.				
2. Argues with adults.				
3. Actively defies or refuses to mind adults' requests or rules.				
4. Deliberately annoys people.				
5. Blames others for his or her mistakes or misbehavior.				
6. Is touchy or easily annoyed by others.				
7. Is angry and resentful.				
8. Is spiteful or vindictive (for example, takes anger out on others or tries to get even).				

Section 3

1. Bullies, threatens, or intimidates others.				
2. Starts physical fights.				
3. Lies to obtain goods or favors or to avoid obligations (that is, "cons" others)				
4. Stays out at night despite parent not allowing him or her to do so.				
5. Is truant for school				

For the items below, circle No or Yes

6. Has used a weapon that can cause serious physical harm to others (for example, a bat, brick, broken bottle, knife or gun)	No	Yes
7. Has been physically cruel to people.	No	Yes
8. Has been physically cruel to animals.	No	Yes
9. Has stolen while confronting a victim (for example, mugging, purse snatching, extortion, armed robbery).	No	Yes
10. Has forced someone into sexual activity.	No	Yes
11. Has deliberately engaged in fire setting with the intention of causing serious damage.	No	Yes
12. Has deliberately destroyed others' property (other than by fire setting).	No	Yes
13. Has broken into someone else's house, building, or car.	No	Yes
14. Has stolen items of nontrivial value without confronting a victim (for example, shoplifting, but without breaking or entering; forgery)	No	Yes
15. Has run away from home overnight at least twice while living at home (or once without returning for a lengthy period).	No	Yes

Thank You!

Rice Clinic
Parent Questionnaire for Children and Adolescents

Referred by_____

Patient Name: _____ Date of Birth: _____ Age _____

School_____Grade_____Teacher _____

Briefly list problems with which you want help:

Family History

Mom _____ DOB _____ Occupation _____

Dad _____DOB _____ Occupation _____

Marital Status (check one): _____ Married _____ Separated _____ Divorced _____ Never Married

Custody Status (check one): ___Joint ___Mom ___Dad ___Other: _____

Step-Parents (if applicable): _____

Siblings' Ages: _____

Briefly list important medical information including any drug allergies:

Prior Treatment and/or Evaluations (Check all that apply):

___ Medication List:
___ Psychotherapy
___ Speech Therapy
___ EEG
___ Vision Checked
___ Learning Disability Evaluation (Date:)
___ Other Therapy:
___ Head CT/MRI
___ Hearing Checked

Do you think your child has lost a previously acquired skill? ___No ___Yes (Explain)

Birth and Developmental History

___Vaginal Delivery ___Cesarean Section (Emergency: ___Yes ___No)
___Premature Hospital Stay: _____ Complications: _____
Condition at Birth (Circle): Good Fair Poor Birth Weight: _____ Oxygen Used? Yes No
Any problems with feeding, breathing, etc., occurring soon after birth?

If adopted, at what age? _____ Do you have info about biological parents?

(Indicate the category that best describes when your child met the following developmental milestones)

SPEECH: ___Within Normal Limits ___Delayed (circle: slightly, severely) ___Advanced
MOTOR: ___Within Normal Limits ___Delayed (circle: slightly, severely) ___Advanced
SOCIAL: ___Within Normal Limits ___Delayed (circle: slightly, severely) ___Advanced
SELF-CARE: ___Within Normal Limits ___Delayed (circle: slightly, severely) ___Advanced

List any medical or psychiatric history of child that is important for us to know:

Is there a family history of neurological, learning, psychiatric, or developmental problems?
___No ___Yes (Describe):

Traits and Behaviors (Check all that apply)

___Sense of Humor ___"People Person" ___Problems with transitions/change
___ Tantrums ___ Head banging ___ Refusal to go to school/daycare

___ Sad
___ Spinning
___ Rocking
___ Intense
___ Kind
___ Hard worker
___ Optimistic
___ Realistic
___ Flapping hands
___ Making odd noises
___ Jerking arms or hands
___ Confuses right & left
___ Creative
___ Resilient
___ Pessimistic
___ Affectionate
___ Over-excitable at times
___ Sensitive to lights or noises
___ Trouble with eye contact
___ Tilts head or squints when reading
___ Poor hand-eye coordination
___ Problems jumping rope, skipping, bicycling, etc.
___ Shyness

Interests

___ Sports
___ Art
___ Music
___ Math
___ Bike riding
___ Building things
___ Dancing
___ School work
___ Cars/Motorcycles
___ Social activities
___ Reading
___ Computer games/work
___ Pets/Animals
___ Writing

Mental Energy (___ Not Applicable)

___ Trouble staying alert
___ Trouble finishing things
___ Picky or poor eater
___ Good & bad days
___ Problems sleeping
___ Loses focus unless very interested
___ Sleepy or exhausted at school

Attention (___ Not Applicable)

___ Daydreams
___ Focuses deeply
___ Bored easily
___ Acts impulsively
___ Interrupts conversations
___ Attention varies depending on subject
___ Trouble staying seated
___ Forgets what just heard
___ Blurts out answers
___ Creative, has lots of ideas
___ Distracted by sounds
___ Distracted by visual details
___ Trouble shifting attention
___ Craves excitement or novelty
___ May focus on unimportant details

Work Production (___ Not Applicable)

___ Trouble planning work
___ Fidgety or overactive
___ Doesn't notice when bothering others
___ Doesn't plan ahead
___ Careless errors
___ A multi-tasker
___ Disorganized with time
___ Punishment doesn't make a difference

Reading Problems (___ Not Applicable)

___ Loses place
___ Skips words
___ Rubs eyes
___ Omits small words
___ Tires easily
___ Reversals
___ Phonics problems
___ Comprehension problems
___ Problems reading aloud

Writing Problems (___ Not Applicable)

___ Handwriting problems
___ Spelling problems
___ Problems putting ideas into words
___ Organization problems

Speech Problems (___ Not Applicable)

___ Problems putting ideas into speech
___ Problems talking informally with family or friends
___ Problems with articulating words

Math Problems (___ Not Applicable)

___ Problems with basic math facts
___ Reversals
___ Concepts
___ Careless errors

Mood Problems (___ Not Applicable)

___ Seems moody
___ Worries a lot
___ Seems sad
___ Fluctuates from being sad to very excited
___ Has talked about killing himself/herself
___ Believes "not smart"
___ Has many fears
___ Has anger outbursts
___ Negative comments about self
___ Has unrealistic ideas
___ Panics
___ Lost interest in favorite activities

Physical Health Problems (___ Not Applicable)

___ Headaches ___ Stomach aches ___ Distracted by background noise
___ Dizziness ___ Hearing problems ___ "What?" or "Huh?" a lot
___ Carsickness ___ Eating problems ___ Makes odd sounds
___ Twitches/Tics ___ Wets bed ___ Toileting issues
___ Complains of blurred or double vision ___ Preoccupied with cleanness
___ Has certain rituals or odd habits ___ Complains "not well" on school days

Social Problems (___ Not Applicable)

___ Lacks close friends ___ Gets picked on or bullied ___ Dislikes recess
___ Rejected by age group ___ Is sad about lack of friends ___ Trouble making new friends
___ Trouble resolving conflicts ___ Relates better to adults or younger children
___ Trouble talking like other kids
___ Trouble relating to opposite sex
___ Says & does things to annoy peers

Aggressive Concerns (___ Not Applicable)

___ Argues a lot ___ Doesn't accept responsibility ___ Trouble with authority
___ Has tantrums ___ Fights with other students ___ Uses bad language
___ Disobeys parents ___ Takes things from others ___ Is mean to animals
___ Won't follow rules ___ Mean to brothers or sisters ___ Stirs up trouble

Stressors/Changes (___ Not Applicable)

___ Death (Relationship to Child: _____ When? _____)
___ Recent Move ___ Change of School ___ Change of Church
___ Marital Conflict b/w Parents ___ Divorce of Parents ___ Remarriage of Parent
___ Family Financial Problems

Child's Family Experience: ___ Good ___ Uneventful ___ Chaotic ___ Traumatic

Child Experienced ___ Physical ___ Verbal ___ Sexual ___ Mental Abuse
Was Abuse Reported? ___ No ___ Yes Investigated? ___ No ___Yes
What was the outcome of investigation?

Witnessed ___ Physical ___ Verbal ___ Sexual ___ Mental Abuse towards <u>Others</u> in Home
Explain:

Substance Abuse in Home: ___ No ___ Yes Explain:

School Information

School _____ Class Size _____

How does your child feel about school? _____

_____

_____

Do you have concerns about his/her class or school placement? ___ No ___ Yes (Explain)

_____

_____

Does your child have an IEP or 504? ___ No ___ Yes

Do you have any concerns about IEP/504? ___ No ___ Yes (Explain) _____

_____

_____

Are Any of the Following Subjects Difficult for your Child?

Subject	Yes	No	Not Sure
Art			
Computers			
English			
Foreign Language			
Handwriting			
Math			
Music			
Note Taking			
Reading			
Science			
Social Activities			
Social Studies/History			
Speaking/Discussion			
Sports/PE			
Creative Writing			
Report Writing			

_____ _____

Person Providing Info/Relationship to Child Parent Signature

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
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

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:_____

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 <u>not</u> 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