



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.

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

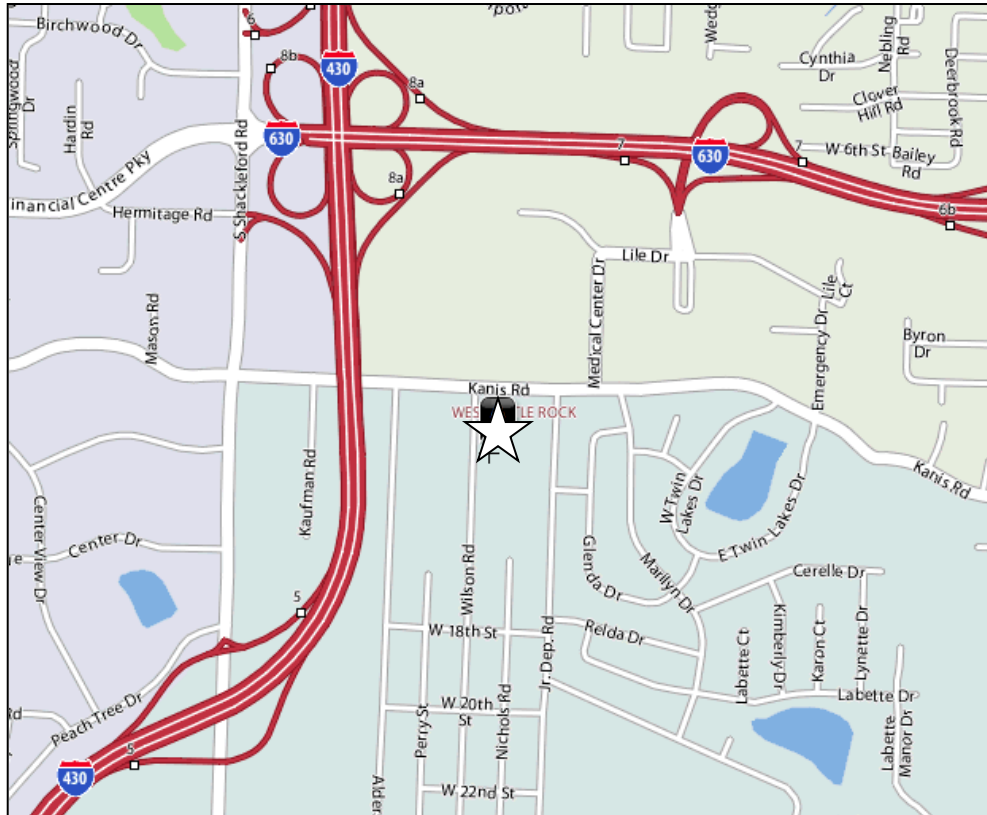
Enclosed you will find your new patient forms. Please complete these forms in their entirety and bring them with you to your appointment. If your forms are not completed by your scheduled appointment time, we will need to reschedule your appointment. Please arrive for your appointment 20 minutes early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

- ROBERT RICE, M.D.
- C. BRENT LAWLIS, M.D.
- SONYA CANIELD,
APRN, PMHNP-BC
- ABEER WASHINGTON, M.D.
- KEVIN ROWELL, Ph.D.
- SUSAN BRYANT, Ph.D.
- DOUG DAMRON, M.S., L.P.C.
- 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., LPE-I



★ **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: _____

<p>ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT unless cancelled twenty-four (24) hours in advance.</p> <p>IN CASE OF DIVORCE: The parent who authorized the child to receive treatment is responsible for payment.</p> <p>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.</p> <p>Patient: _____ Date: _____ Signature: _____ Relationship: _____</p>

<p>PERMISSION FOR TREATMENT: I give permission to the Rice Clinic to treat the above registered minor.</p> <p>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.</p> <p>Signature: _____ Date: _____ Relationship: _____</p>

<p>I give my permission for my child (who is a licensed driver) to drive to and from the clinic for appointments.</p> <p>Signature: _____ Date: _____ Relationship: _____</p>
--

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 not 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 Psychotherapy Learning Disability Evaluation (Date: _____)

List: Speech Therapy Other Therapy:

EEG Head CT/MRI

Vision Checked 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

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

Interests

- | | | | |
|---------------------------------|--|--|--|
| <input type="checkbox"/> Sports | <input type="checkbox"/> Bike riding | <input type="checkbox"/> Cars/Motorcycles | <input type="checkbox"/> Computer games/work |
| <input type="checkbox"/> Art | <input type="checkbox"/> Building things | <input type="checkbox"/> Social activities | <input type="checkbox"/> Pets/Animals |
| <input type="checkbox"/> Music | <input type="checkbox"/> Dancing | <input type="checkbox"/> Reading | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Math | <input type="checkbox"/> School work | | |

Mental Energy (Not Applicable)

- | | | |
|---|--|---|
| <input type="checkbox"/> Trouble staying alert | <input type="checkbox"/> Good & bad days | <input type="checkbox"/> Loses focus unless very interested |
| <input type="checkbox"/> Trouble finishing things | <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Sleepy or exhausted at school |
| <input type="checkbox"/> Picky or poor eater | | |

Attention (Not Applicable)

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

Work Production (Not Applicable)

- | | | |
|---|---|---|
| <input type="checkbox"/> Trouble planning work | <input type="checkbox"/> Doesn't plan ahead | <input type="checkbox"/> A multi-tasker |
| <input type="checkbox"/> Fidgety or overactive | <input type="checkbox"/> Careless errors | <input type="checkbox"/> Disorganized with time |
| <input type="checkbox"/> Doesn't notice when bothering others | | <input type="checkbox"/> Punishment doesn't make a difference |

Reading Problems (Not Applicable)

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Loses place | <input type="checkbox"/> Omits small words | <input type="checkbox"/> Phonics problems |
| <input type="checkbox"/> Skips words | <input type="checkbox"/> Tires easily | <input type="checkbox"/> Comprehension problems |
| <input type="checkbox"/> Rubs eyes | <input type="checkbox"/> Reversals | <input type="checkbox"/> Problems reading aloud |

Writing Problems (Not Applicable)

- | | |
|---|--|
| <input type="checkbox"/> Handwriting problems | <input type="checkbox"/> Problems putting ideas into words |
| <input type="checkbox"/> Spelling problems | <input type="checkbox"/> Organization problems |

Speech Problems (Not Applicable)

- | | |
|---|---|
| <input type="checkbox"/> Problems putting ideas into speech | <input type="checkbox"/> Problems with articulating words |
| <input type="checkbox"/> Problems talking informally with family or friends | |

Math Problems (Not Applicable)

- | | | | |
|---|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Problems with basic math facts | <input type="checkbox"/> Reversals | <input type="checkbox"/> Concepts | <input type="checkbox"/> Careless errors |
|---|------------------------------------|-----------------------------------|--|

Mood Problems (Not Applicable)

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

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 Others 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

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. Multiple missed appointments or 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