Mona Venzon Rice, MD
Board Certified Child & Adolescent Psychiatrist
100 District Dr. #218
Asheville, NC 28803
P 828 774 5068 F 575 5448

New Patient Forms

RETURN THIS PAGE TO OFFICE STAFF OR DOCTOR

Person Completing this Form: _____ Date:_____

Patient Information:

Full Name_____ Date of Birth: _____

Address:_____

Street / PO Box City State Zip Code

Phone #:_____ Email Address: _____

(Pls. write the info below even if self-paying Dr. Rice for visits, because it may be needed for prescriptions:)

Health Insurance Company & ID# _____

Parent / Guardian Information (Please list all):

Name >>>>>>>>>>	_____	_____	_____	_____
Relationship To Patient >>>>>>>	_____	_____	_____	_____
Phone # >>>>>>>>	_____	_____	_____	_____
Address if different From Patient >>>>>	_____	_____	_____	_____
Has/shares legal Custody Yes or No?	_____	_____	_____	_____

I give Dr. Rice and office staff permission to leave a message for me at this phone no: _____

In Case of Emergency, please call: _____ _____ _____

Name Phone # Relationship to patient

Reasons for Consultation: _____

_____

_____

Referred by: _____ Contact Info*:* _____

Current Primary Care Doctor: _____ Contact Info: _____

Past Psychiatrist: _____ Contact info: _____

List All Medical Conditions:

_____

_____

List All Current Medications (Psychiatric & Other), Dosages and Frequency:

_____

_____

_____

Drug Allergies and Adverse Reactions:

_____

*Preferred Pharmacy:*_____Location:_____Phone No:_____

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PATIENT'S COPY

Patient Agreement

Set forth below is the Patient Agreement with Dr. Rice, which establishes guidelines for participation in evaluation and treatment. Please carefully read the following paragraphs and ask Dr. Rice or staff any questions. If, after reading and considering this Patient Agreement, you agree to everything set forth below, please sign where indicated.

Purpose and Scope of Doctor-Patient Relationship

The purpose of seeing Dr. Rice is for evaluation and treatment only. Dr. Rice's scope of practice does not include evaluations for forensic, legal or custody purposes. Dr. Rice does not perform disability evaluations.

Treatment – What to Expect

The initial evaluation consists of one 50-60 minute session. The purpose of these is to obtain a comprehensive history for an accurate assessment of the patient's difficulties. Dr. Rice may need to obtain collateral information from other providers such as doctors, teachers and therapists before generating a more definitive diagnosis and recommendations. At the end of the initial evaluation, medication may or may not be recommended.

Follow-up visits consist of 20-40 minute sessions. During follow-up appointments, the following may be discussed: clinical observations, results of diagnostic tests, information received from other providers, response and side effects to medications, initiation and adjustment of medications, counseling, psychoeducation and referrals.

Fee Schedule for Visits

Description	**Fee**
New Patient Evaluation (50-60 minutes)	$275
Follow-up Appointment (20-40 minutes)	$140

Payment and Insurance Information

Dr. Rice is currently in-network with NC Health Choice and NC Medicaid, but out-of-network with all private insurance.

It is important that you understand your insurance benefits. Your insurance is a contract between you and your insurance provider, and there is no guarantee of benefits. Your insurance company will only pay for services covered under your contract. We urge you to contact your insurance company before your appointment to ask about out-of-network claims and reimbursement for psychiatric services.

We accept payment of fees and co-pays in the form of cash, checks, VISA, Mastercard, Discover & American Express. Checks should be written out to: "Mona Venzon Rice, MD, PC." There is a returned check fee of $35.00.

The following information is for those with private insurance: Dr. Rice is currently not a participating provider ("in network") with any private insurance plan. She accepts direct / fee-for-service / out-of-pocket payment for all her services. Payment is due in full at the time of your appointment. If you wish to file the expense as an "out of network" claim with your insurance, we will provide you with an invoice / superbill that you can submit to your insurance company for reimbursement. We will not file the claim for you.

Unpaid Balances

If we are unable to collect on a balance owed, legal means may be used to secure payment, which may include hiring a collection agency. Unless the balance is paid, Dr. Rice may be unable to continue treatment.

Appointment Policy

To schedule an appointment, call the office to speak with our office manager. Please be advised that you will be charged for the full amount of time that was allotted for your appointment. Scheduled appointments are reserved strictly for you and for no one else. Because of this, a 2- business-day notice to cancel or change your appointment is required. No-shows, missed and late cancellations (less than 2 business days before the scheduled appointment) may be charged according to the schedule listed below. Patients with NC Medicaid and NC Health Choice will not be charged these fees; however, after multiple missed or late-cancelled appointments, Dr. Rice may end their treatment with her.

Description	**Fee**
Missed Appointment / No Show / Late Cancellation-- New Patient Evaluation	$190
Missed Appointment / No Show / Late Cancellation-- Follow-up	$90

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Prescriptions and Refills Outside of Appointments

Dr. Rice does not routinely refill or authorize prescriptions outside of appointments. During your visits, Dr. Rice will recommend when you should come back. The amount of medications prescribed will be enough up to the recommended follow-up appointment. It is expected that you attend the appointment on time so Dr. Rice can re-assess response and effects to medications. She will authorize or refill prescriptions as seen fit, during the visit.

If you cancel or miss an appointment, be sure to reschedule it before medications are scheduled to run out. If for some reason, prescriptions are going to run out before the next scheduled visit, please make an effort to call the office at least 3 business days prior to running out. It is Dr. Rice's prerogative whether or not to refill medications outside of scheduled appointments. Dr. Rice may require you or your child in for a session before she can provide refills.

Refills for non-controlled substances may be electronically sent, faxed or called in to your pharmacy, or may be written and printed for you. Controlled medication prescriptions can be electronically sent to your pharmacy or may be written and printed for you; some may or may not be called in or faxed to pharmacies. Please give 3 business days' notice for prescription refills. You will need to pick these up from the office.

If for some reason, Dr. Rice or the office cancels your appointment and prescriptions run out as a result, Dr. Rice will make every effort to refill prescriptions as soon as possible.

Forms and Paperwork Done Outside of Appointments

Any forms and paperwork that require extensive effort or extended time to accomplish may incur charges depending on complexity, data to be reviewed and amount of time needed. Examples include but are not limited to: documentation to obtain educational accommodations in school, select disability-related documentation and FMLA forms. A notice of five (5) business days is needed for completion of paperwork.

Communication

Phone: If you need to contact Dr. Rice between scheduled appointments, please call the office number. If Dr. Rice is unavailable, please leave a message, including your phone number even if you think that she has it. Dr. Rice will make every effort to return phone calls within a reasonable amount of time.
Fax: You may fax information to our fax number.
Maill: You may mail information to our office address.

Emergencies / Urgencies / After-Hours/24-7 Access

For an urgent matter, please call the office number and we will make an effort to provide an urgent appointment within 48 business hours. If it is after hours, weekends or holidays, and you need emergency assistance by phone, please call 828 713 8052.

For genuine emergencies including imminent harm to self and others, call 911 or go to the nearest emergency room. For any behavioral or psychiatric crisis, you may also call the county mobile crisis management services 24 hours/7 days a week at 1 888 573 1006 (for Buncombe County residents). For other counties, see https://www.ncdhhs.gov/providers/lme-mcodirectory).

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Patient Name: _____ Date of Birth: _____

Acknowledgment

If any part of this Patient Agreement, including Attachments, is held to be unenforceable, the remainder of this Patient Agreement will remain in effect.

By signing below, you acknowledge that you have read, understand and agree to abide by the terms of this Patient Agreement in its entirety.

_____ _____
Signature of Patient (if 18 & above) / Parent or Legal Guardian (if 17 & below) Date Signed

Consent for Treatment

I, individually or in my capacity as the legally responsible person for the person receiving services, voluntarily authorize and consent to treatment / habilitation, including psychiatric diagnostic, preventative and therapeutic services by Dr. Mona Venzon Rice. I understand that there are both benefits and risks to psychiatric treatment. I understand that medication, a medical procedure or mental health treatment is only one aspect of the treatment plan and that success and continued improvement depends on my active involvement in treatment planning. Although this medication or procedure is expected to be helpful in the treatment of the condition, there is no guarantee that improvement will be seen. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I have been informed of my right to consent to or refuse treatment. I understand that I have the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental health, intellectual or developmental disability or substance abuse.

In case of an emergency, I authorize Dr. Mona Venzon Rice to obtain emergency treatment/habilitation from any necessary physician, emergency room, and/or emergency transportation service.

For parents or legal guardians: By signing below, you agree that you have legal authority to consent to the patient's treatment. You agree that if you share custody or guardianship with another person, it is your responsibility to communicate with the other custodian / guardian regarding the treatment, in accordance with the custody court order, divorce or guardianship decree.

_____ _____
Signature of Patient (if 18 & above) / Parent or Legal guardian (if 17 & below) Date Signed

Acknowledgment of Responsibility for Payment

I agree that I am financially responsible for all services that I or my child utilizes and that my account is due in full each session. I have been informed of the doctor's fees for visits, phone consultations, and other services. I have been informed of the doctor's cancellation policy and my responsibilities related to this.

The adult accompanying a minor is responsible for full payment. This is regardless of any divorce decree (which is a contract between the parents; not between you and your doctor). If an adult other than the adult accompanying a minor is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the physician fees at the time of service and may collect reimbursement from the responsible adult.

I understand that during the course of treatment, it may become necessary to increase fees to compensate for increased costs and inflation. Fees will be reviewed periodically and will be increased no more than once during any calendar year.
By signing below, you state that you have read and you agree to this Acknowledgment of Responsibility for Payment in its entirety.

_____ _____
Signature of Patient (if 18 & above) / Parent or Legal guardian (if 17 & below) Date Signed

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Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Patient Address:_____
Street/P.O. Box City State Zip Code

I authorize Mona Venzon Rice, MD

□ To release PHI to: □ To obtain PHI from: □ To exchange PHI with

For the purpose of (Check):
□ Coordination & continuity of care □ Legal matter
□ Personal use □ Other purpose (specify) _____
I authorize the following PHI to be disclosed (Check):
□ In-person, telephone, and/or electronic communication □ Complete record
□ Intake/discharge □ Progress notes
□ Other PHI (specify) _____

INITIAL:

____This authorization may be relied upon when transmitted by fax. I further authorize the PHI to be sent by fax. I agree to hold Mona Venzon Rice, MD harmless if any PHI transmitted by fax does not reach the authorized recipient.

____I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

___ I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

___ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

___I further understand that I may request a copy of this signed authorization.

_____ _____
Signature of Patient (if 18 & above) / Parent or Legal Guardian (if 17 & below or has a legal guardian) Date

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Acknowledgment of Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the Notice of Privacy Practices from Mona Venzon Rice, MD. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider.

I understand that my signature on this Acknowledgment only signifies that I have received a copy of the Notice, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my healthcare provider, whether I sign this Acknowledgment or not.

_____
Patient Name

_____ _____/_____/_____
Patient's Name Date of Birth

_____ _____
Signature of Patient (if 18 & above) / Parent or Legal guardian (if 17 & below or has a legal guardian) Date Signed

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for ex., home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

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Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost -based fee if you ask for another one within 12 months.

Get a copy of this privacy notice You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated.
  - You can complain if you feel we have violated your rights by contacting us using the information below.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints.**
- We will not retaliate against you for filing a complaint.

OUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.* **Bill for your services** We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety **Do research** We can use or share your information for health research.

Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services **Respond to lawsuits and legal actions** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:**www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Changes to the Terms of this Notice** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.

Privacy official: Mona V. Rice, MD