Mona Venzon Rice, M.D., P.C.
Pediatric Psychiatrist

100 District Dr. #218
Asheville, NC 28803
P 828 774 5068 F 575 5448

Patient Information Sheet

Person Completing this Form: _____ Date:_____

Patient's Full Name:_____ Date of Birth: _____

Full Address:_____

Phone #:_____ E-mail Address: _____

(Pls. write the info below even though Dr. Rice is not participating in insurance, because it may be needed for prescriptions:)

Health Insurance Company & ID# _____

For patients age 17 & below or under guardianship: *Parent / Guardian Information (Please list all):*

Name			
Relationship to Patient			
Phone #			
E-mail Address			
Address if Different			
Shares legal custody? Y or N			

*Reasons for Consultation:*_____

_____

_____

_____

Referred by: _____ Phone #: _____ E-mail: _____

Current Primary Care Doctor: _____ Phone #: _____ E-mail: _____

Past Psychiatrist (if any): _____ Phone #: _____ E-mail: _____

*Current Therapist (if any):*_____ Phone #: _____ E-mail: _____

List All Medical & Psychiatric Conditions:

_____

_____

_____

_____

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

_____

_____

_____

_____

Drug Allergies: _____

*Past Psychiatric Medications & Response:*_____

_____

_____

*Preferred Pharmacy:*_____ Street / Location:_____ Phone #:_____

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Patient's Printed Name: _____

Set forth below is the 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 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 formal disability evaluations.

Appointment Policy

To schedule an appointment, please call the office to speak with office staff. A 2- business-day notice to cancel or change your appointment is required. No-shows, missed appointments and late cancellations (made less than 2 business days before the scheduled appointment) will be charged 50% of the visit fee using your credit card on file. After 3 successive no-shows, missed appointments or late cancellations, Dr. Rice reserves the right to discontinue treatment. Should you decide to end care with Dr. Rice or transfer to a different practitioner, please inform Dr. Rice or office staff. If we do not hear from you or if you do not schedule or come in for a visit for a continuous period of 6 months, you will be considered inactive and it may be assumed that you have decided to end care with Dr. Rice.

Prescriptions and Refills

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. 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 three (3) business days prior to running out. It is Dr. Rice's prerogative to refill medications outside of scheduled appointments. Dr. Rice may require you / your child in for a session before she can provide refills.

Forms and Paperwork

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.

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

For an urgent matter, please call the office number. If needed, an urgent appointment within 48 business hours may be provided. If it is outside of office hours, weekends or holidays, and you need urgent assistance by phone, please call 828 713 8052.
For genuine emergencies including imminent harm to self and others or worsening symptoms compromising safety, please 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 http://crisissolutionsnc.org/north-carolina-crisis-services-by-county/).

Informed Consent

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, preventive 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. 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 custody court order, divorce or guardianship decree, if applicable.

_____

Signature of Patient (if 18 & above) or Signature of Parent or Legal guardian (if 17 & below or if adjudicated as ward)	Signer's Printed Name	Date Signed

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Pediatric Psychiatrist

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Patient's Printed Name: _____

Telehealth Consent

Signing below gives you the option to visit Dr. Rice via telehealth, in addition to office visits. Through telehealth, you can talk from any place with audio and video by phone, computer or tablet and avoid having to go to the office. Benefits of telehealth include: 1) lower risk of getting sick from other people, 2) convenience, 3) save time and effort. Risks of telehealth include: 1) your doctor may make a mistake due to miscommunication or inability to examine you as closely, 2) your doctor may decide you still need an office visit and 3) technical problems may interrupt or stop your visit. Privacy of telehealth visits is maintained by: 1) not recording the visits, 2) using HIPAA-complaint telehealth technology and 3) locating yourself in a private place and 4) using internet service that is secure, encrypted and password-protected. There is a small chance that someone could use technology to hear or see your telehealth visit.

_____

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Financial Policy

Credit Card on File

A valid credit card is required to schedule appointments. This card will be used to charge for no-show, missed appointment or late cancellation fees when appropriate. You will be notified at the time of remittance of these charges. Credit card information is stored in a Payment Card Industry Data Security Standard (PCI DSS) – compliant database.

Payment and Insurance Information

Dr. Rice is currently <u>not participating with any government (e.g. Medicaid) or private health insurance.</u> You are responsible for the full cost of services. Payment is due in full at the time of the appointment. Dr. Rice will not file any claims to insurance for you. The following forms of payment are accepted: cash, checks, VISA, Mastercard, Discover & American Express. Checks should be written out to: "Mona Venzon Rice, M.D., P.C." There is a returned check fee of $35.00.

Unpaid Balances

If 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.

Acknowledgment of Responsibility for Payment and Financial Policy

I have read the above financial policy. I agree that I am financially responsible for payment for all services that I, individually or as the legally responsible person for the person utilizing services, receive and that my account is due in full each session. I have been informed of the doctor's fees. 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 parents, not between you and your doctor). The adult accompanying the minor may later 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.

_____

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Acknowledgment of Receipt or Availability of Privacy Notice

A copy of the Privacy Notice is accessible on the practice website and/or the office. I hereby affirm that I have been given access to or received a copy of the Notice of Privacy Practices from Mona Venzon Rice, M.D., P.C. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider whether I sign this Acknowledgement or not. I understand that my signature on this Acknowledgment only signifies that I have been provided access to or received a copy of the Notice and does not legally bind or obligate me in any way.

_____

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Communications Consent

Mona Venzon Rice, M.D., P.C. respects your right to confidential communications and your right to direct how those communications occur. Mona Venzon Rice, M.D., P.C. uses HIPAA-compliant electronic health record and e-mail system that use Transport Layer Security (TLS) for encryption. Inbound and outbound e-mails are encrypted. But any e-mail sent to a party not using a TLS-supported mail server will be unencrypted. Also, once an e-mail is received by the recipient, someone else may be able to access the e-mail and read it. Some viruses can cause e-mail messages to be sent to people to whom you do not intend to send e-mail. Text messages, voicemail and answering machine messages may also be intercepted by others.

Mona Venzon Rice, M.D., P.C. will use reasonable means to protect your private health information (PHI) when communicating with you, parties authorized by you and parties authorized by law. However, because of the risks outlined above, Mona Venzon Rice, M.D., P.C. will not be liable in the event that you or anyone else inappropriately accesses e-mail, text messaging, voicemail or answering machine, nor will it be liable for improper disclosure of your health information that is not caused by Mona Venzon Rice, M.D., P.C.'s intentional misconduct.

You may choose to limit the type of e-mail, text, voicemail and answering machine communication. Please indicate below what types of correspondence you consent to transmit through each method.

	E-mail	Text Message	Voicemail	Answering Machine
Appointment	☐	☐	☐	☐
Billing & Payment	☐	☐	☐	☐
Test Result	☐	☐	☐	☐
Medical Condition, Update & Advice	☐	☐	☐	☐

By signing this form, I acknowledge that I have read and fully understand the risks associated with the communications by e-mail, text messaging, voicemail and answering machine, and I consent to communications between Mona Venzon Rice, M.D., P.C. and me, with parties authorized by me and parties authorized by law.

_____

Signature of Patient (if 18 & above) or Signature of Parent or Legal guardian (if 17 & below or if adjudicated as ward) | Signer's Printed Name | Date Signed

(This Section is <u>only</u> for patients 18 years old and above)

Consent for release of Protected Health Information (PHI) to family or designated person(s)

I consent to the disclosure of the following PHI about me to the following family member(s) or person(s) involved in my care and/or payment for my care.

Name	Phone #	E-mail	Information
			☐Appointment ☐Billing & Payment ☐Prescription ☐Paperwork ☐Medical Conditions, Update & Advice ☐Emergency
			☐Appointment ☐Billing & Payment ☐Prescription ☐Paperwork ☐Medical Conditions, Update & Advice ☐Emergency
			☐Appointment ☐Billing & Payment ☐Prescription ☐Paperwork ☐Medical Conditions, Update & Advice ☐Emergency

My consent will remain in effect as long as I am a patient of Dr. Mona Venzon Rice unless I notify her of changes in writing.

_____

Signature of Patient (18 & above) | Patient's Printed Name | Date Signed

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Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I authorize Mona Venzon Rice, M.D., P.C. (Check all that apply.)

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

Name	E-mail	Phone # / Fax #	Information (Check all that apply)
☐Psychological therapist Or Counselor			☐complete record / all information ☐progress ☐treatment ☐history ☐evaluations ☐test results ☐discharge summary ☐other: _____
☐Primary care practitioner:			☐complete record / all information ☐progress ☐treatment ☐history ☐evaluations ☐test results ☐discharge summary ☐other: _____
☐Name of School & Staff (e.g. teacher, counselor)			☐medical conditions & treatment ☐doctor's recommendations for school ☐school behaviors ☐rating scales ☐educational evaluation/plan ☐other: _____
☐Other:			☐complete record / all information ☐progress ☐treatment ☐history ☐evaluations ☐test results ☐discharge summary ☐other: _____

For the purpose of (Check all that apply)

☐Assessment & treatment ☐Legal matter ☐Other: _____

☐Coordination & continuity of care ☐Personal use

-This authorization may be relied upon when transmitted by fax or e-mail. I further authorize the PHI to be sent by fax or e-mail. I agree to hold Mona Venzon Rice, MD harmless if any PHI transmitted by fax or e-mail 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, or up to 2 years, whichever is earlier, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. 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.

_____

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