PATIENTS NAME:_____DATE:_____ Insurance_____

Age:_____ DOB:_____ SEX: M___ F___ RACE: White___ African American___ Other___

PRESENTING PROBLEM:
_____
_____

CURRENT PSYCHOSOCIAL STRESSORS:
_____
_____

PREVIOUS PSYCHIATRIC HISTORY (Hospitalizations), COUNSELING AND TREATMENT:
_____
_____

ALCOHOL AND DRUG HISTORY:
_____
_____

MEDICAL HISTORY:
_____
_____ Pain_____

PHYSICAL OR SEXUAL HISTORY:
_____
_____

CURRENT PSYCHIATRIC MEDICATIONS:
_____
_____

PRESCRIBING PHYSICIAN:_____ PHONE: _____
ADDRESS: _____

FAMILY HISTORY:
_____
_____
_____
_____
_____
_____
___

SIBLINGS:_____
_____
_____

FAMILY HISTORY OF MENTAL ILLNESS:
_____
_____

MARITAL AND DATING HISTORY:
_____
_____
_____

CHILDREN:_____
_____
_____

LEGAL PROBLEMS:_____
ANGER PROBLEMS:_____
EDUCATION HISTORY:_____

OCCUPATIONAL EVALUATION (PRESENT STATUS):
Employed_____ Unemployed_____ Laid-off_____ Disabled_____
Occupation: _____

Physician to Complete

MENTAL STATUS

GENERAL APPEARANCE: ___Well Groomed ___Disheveled ___Bizarre ___Inappropriate
ATTITUDE: ___Cooperative ___Guarded ___Suspicious ___Uncooperative ___Belligerent
Comment:_____

PSYCHOMOTOR ACTIVITY: ___Calm ___Hyperactive ___Agitated ___Tremors-Tics
Comment:_____

AFFECT: ___Appropriate ___Labile ___Expansive __Constricted ___Blunted ___Flat
MOOD: ___Euthymic ___Depressed ___Anxious ___Euphoric
SPEECH: ___Normal ___Delayed ___Soft ___Loud ___Stutter ___Slurred ___Excessive ___Pressured __Preservation

DEPRESSION:_____ APPETITE:_____ SLEEP:_____
Hopelessness_____ Sadness_____ Memory: recent_____ remote_____
Concentration_____ Insight /Judgment _____
Self Care and Hygiene_____ Irritability_____ Mood Swings_____ Fatigue_____

Suicidal thoughts or Plans:
_____
_____

Hyperactivity or Manic Episodes: talks excessively ___ flight of ideas ___ fidgets or squirms ____
Easily distracted ___ poor organization ___ doesn't seem to listen ___ doesn't follow through on things ____
Looses things ___ poor attention when doing things ___ interrupts others ___
Comments _____

BEHAVIOR PROBLEMS: defies adult requests ___ annoys others ___ blames others ___
touchy and easily annoyed ___ angry or resentful ___ spiteful___ few friends___ bullies___
doesn't follow through on things___ loses things___ poor attention when doing things___ interrupts others___
Comments _____

ANXIETY CONDITION: panic___ phobias___ vertigo___ gastrointestinal disturbance___
Comments _____

EATING DISORDER SYMPTOMS
_____
_____

MENTAL STATUS:
Homicidal Ideation or Plan: _____No _____Yes
Comments_____

Thought process: intact__ circumstantial__ loosening of associations__ tangential__ flight of ideas__

HALLUCINATIONS:_____

DELUSIONS:_____

ORIENTATION: Self___ Time___ Place___ Person___ IQ Estimate_____

DIAGNOSTIC IMPRESSIONS

AXIS I:_____
AXIS II:_____
AXIS III:_____
AXIS IV:_____
AXIS V: CURRENT_____ PAST YEAR_____

RISKS EXPLAINED: Death_, SI_, Sedation_, EPS/TD_, DM_, Wt^_, (Current Wt:_____), Card/vasc_, Liver_, Pancreatitis_, Hematology_, Renal_, Seizure_, Priapism_, Pregnancy_, Location_, _____
FOLLOW UP: Psychiatry_____, PCP_____, Counseling_____
ADVICE: Use emergency service if SI/HI arise_, Review meds w PCP_, Don't drive if sedated/confused_, No drugs/ alcohol_, inform MD if pregnant_, Maintain fluid balance_, Read meds ed material_, Sleep hygiene_, Exercise/ diet_, Caregiver to control meds_.

Treatment Plan and Recommendations:
_____
_____
_____
_____
_____
_____
_____
_____

Progress
Notes:_____
_____
_____
_____
_____
_____
_____

SIGNATURE_____ DATE_____
Rolando Larice, MD

ROLANDO LARICE, MD & ASSOCIATES

711 Old Ballas Road, Suite 203
Creve Coeur, MO 63141
Phone: 314.434.9181 Fax: 877.707.7924

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN
MAIDEN NAME	EMAIL	MARITAL STATUS		
STREET ADDRESS			APT. NO.	
CITY	STATE	ZIP CODE	HOME PHONE	
SOCIAL SECURITY NUMBER	AGE	GENDER	CELL PHONE	
EMPLOYER	OCCUPATION	WORK PHONE		
EMERGENCY CONTACT (NOT LIVING WITH YOU) RELATIONSHIP TO PATIENT			EMERGENCY CONTACT PHONE	

FINANCIALLY RESPONSIBLE PARTY INFORMATION (SELF, SPOUSE OR PARENT)

LAST NAME	FIRST NAME	M.I.		RELATIONSHIP TO PATIENT
STREET ADDRESS		APT. NO.	HOME PHONE	
CITY	STATE	ZIP CODE		CELL PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH			
RESPONSIBLE PARTY EMPLOYER		OCCUPATION	WORK PHONE	

SECOND PARENT INFORMATION

LAST NAME	FIRST NAME	M.I.		RELATIONSHIP TO PATIENT
STREET ADDRESS		APT. NO.	HOME PHONE	
CITY	STATE	ZIP CODE		CELL PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH			
EMPLOYER		OCCUPATION	WORK PHONE	

INSURANCE INFORMATION

INSURANCE COMPANY NAME	COPAY	EFFECTIVE DATE
I.D./POLICY NUMBER	GROUP NUMBER	
SUBSCRIBER	RELATIONSHIP TO PATIENT	DATE OF BIRTH
SUBSCRIBER EMPLOYER	SUBSCRIBER SOCIAL SECURITY NUMBER	

SECONDARY INSURANCE CARRIER

INSURANCE COMPANY NAME	COPAY	EFFECTIVE DATE
I.D./POLICY NUMBER	GROUP NUMBER	
SUBSCRIBER	RELATIONSHIP TO PATIENT	DATE OF BIRTH
SUBSCRIBER EMPLOYER	SUBSCRIBER SOCIAL SECURITY NUMBER	

Insurance Payment Authorization and Release: I authorize my insurance benefits to be paid directly to this physician's office. I acknowledge that I am financially responsible for any unpaid balances. I also authorize the release of any information requested by my insurance companies.

Patient/Responsible Party/Parent Signature: _____ Date: _____

Patient and/or Responsible Party Email:_____

_____

ROLANDO LARICE, MD & ASSOCIATES

711 Old Ballas Road, Suite 203
Creve Coeur, MO 63141
Phone: 314.434.9181 Fax: 877.707.7924

Welcome!

Below are some very important facts regarding my practice rules and regulations. This information will help to maximize your care and allow us to serve you in the most efficient way. Your treatment is very important to me and I ask that you review the following to ensure that you receive the best reasonable care possible. Please complete the signature portion of the form and bring it to your first appointment.

INITIAL _____ **PHONE SYSTEM:** If you are calling after hours and you are experiencing an emergency situation, please hang up and dial **911 or GO TO THE NEAREST EMERGENCY ROOM**. The phones are answered between **9AM and 5PM,** Monday thru Friday. We check the system frequently to ensure that all calls are answered promptly. Please note that at times the providers must be contacted before the staff can respond to your request. All calls are returned within 24 hours. If you are calling after hours and it is an EMERGENCY ONLY, you can call our exchange thru our main phone number. Please note that the exchange is for emergency situations only. Refills, appointments, and non-emergency situations will not be handled after hours.

INITIAL_____ **APPOINTMENTS:** Upon being seen, you will be given a follow up appointment. It is very important you keep this appointment. Patients who do not keep their follow up appointments will not continue to receive medications. Should you need to reschedule your appointment please notify the office as soon as possible so that we can get you another appointment as close to your follow up as possible. If you do not cancel your appointment within 24 hours you are subject to a **$75.00** no show/late cancellation fee. You may reach the office by calling **314.434.9181.**

INITIAL_____ **PROBLEMS:** At times you may experience situational difficulties or require a medication adjustment before your scheduled appointment. Please contact the office during office hours to make an urgent appointment so that you can be assessed in the office. You may leave a message with the office staff by calling **314.434.9181.**

INITIAL_____ **MEDICATIONS: <u>Medication refills are by appointment only</u>. YOU MUST MAKE AN APPOINTMENT FOR ALL PRESCRIPTION REFILLS.** Please call at least **one week prior to running out of medication.**

INITIAL_____ **CHARGES:** A fee of **$375.00** for an initial evaluation, and a fee of **$150.00** for each follow up session is the charge for all self pay patients and are due at the time of service. Suboxone will be charged at **$375.00** for the first five visits, and then charged to the patient's insurance, given it covers Suboxone treatment. If not, the patient will be charged and an ongoing visit rate of **$150.00**. This fee is also charged if a patient loses insurance coverage or has a lapse in insurance coverage. It is the patient's responsibility to inform the office all insurance changes. You will be charged for any collection fees or legal action fees if you are turned over to a collection agency and legal action is necessary. All payments made for service shall be made by cash or credit card. **CHECKS will not be accepted. All copays and Co-insurance is due at time of service.**

INITIAL_____ **PROCESSING FEE:** We will charge **$35.00** per page for a processing fee for any paperwork that needs to be filled out for the patient. We accept all major credit and debit cards and cash. A fee of **$25.00** will be charged for all returned checks submitted by mail. We will gladly file your insurance claim for you, provided that you bring in your insurance card and information. Any portion that is not covered by your insurance company will be your responsibility. If we have not received payment within 45 days from your insurance company, the balance will be transferred to the patient's responsibility and you will be billed for the charges. FMLA and disability paperwork will be charged but pricing will be determined at the office.

This office cannot accept responsibility for collecting your insurance claims or for negotiation a settlement on a disputed claim. Any portion of the bill, the insurance company has not paid, or has been denied will be the patient's responsibility. It is your responsibility to notify our office of any insurance changes, as well as obtaining authorization for your care. Non-treatment proceedings include: Appearances in court, medical records, letters, forms, depositions, family services and any other service not directly related to treatment. Clients assume all financial responsibility for non-treatment services. Please notify the office as soon as possible as it takes 1-2 weeks for the office staff to complete your request.

INITIAL_____ **FINANCIAL RESPONSIBILTIES:** You are responsible for providing us with the correct insurance information at **EVERY** visit. You are solely responsible for educating yourself about your insurance mental health benefits. Understanding deductibles and co-insurance rules will save you money, the stress of unexpected bills, and repeated requests from your insurance company for information before they remit their payment. Please note that payment plans are always an option if you are unable to pay your balance all at once. If you would like to set up arrangements please contact our billing department.

INITIAL_____ **CANCELLATIONS:** We ask that you kindly give us **24 HOUR NOTICE** if you are unable to keep your scheduled appointment. Patients who **DO NOT GIVE 24-HOUR NOTICE OF CANCELLATION WILL BE CHARGED $75.00.** Insurance companies will not pay for these types of charges therefore payment will be due by you.

INITIAL_____ **APPOINTMENT POLICY:** After **THREE** missed appointments without a call to cancel in advance, we reserve the right to terminate the provider/patient relationship. If you are late for a scheduled appointment, it may be necessary for us to reschedule your appointment due to the volume of scheduled patients to be seen. All patients under the age of 18 must be accompanied by parent or legal guardian to all visits involving medical decision making. Legal documentation outlining the right to make medical/psychiatric decisions for the patient must be provided for all cases involving divorce, foster or adoptive placement. Failure to do so may result in rescheduling of appointment.

INITIAL_____ **DISABILITIES:** Patient understands that Dr. Larice, or any other provider seeing the patient within this office does not make a determination regarding the patient's status for Social Security Disability or any other disability program. This office is not responsible for the outcome of decisions by any organization, for which patient has asked for paperwork to be submitted. Accordingly, patient will be charged the applicable rate for any paperwork requested for completion by this office and to be submitted for disability determinations.

INITIAL_____ **TELEPHONE CONSULTATIONS**: All self-pay patients covered by commercial health insurance carriers will be charged for telephone consultations, at our normal hourly rate of $125.00 per hours and $250.00 per hour after hours. We regret that this policy has to be instituted. We have tried to keep our charges as low as possible, without sacrificing the quality and individualized time spent with each patient. Unfortunately, this policy is necessary due to increasing administrative costs of government regulation and general overhead.

Please sign below to indicate that you have reviewed and are aware of the office policies and procedures.

Respectfully,

Rolando Larice, M.D. & Associates

Patient Name (please print)

Signature of Patient/ Guardian Date

TELEPHONE POLICY

If you call the office and your call goes to a voice mail, our staff is on the phone assisting other patients, calling insurance carriers and other phone situations. Understanding this situation will resolve aggravation on the part of patients and others calling into the office on a daily basis.

On heavy call volume days, only urgent calls will be returned the same day. All others will be prioritized and called as soon as it is possible for my staff to do so. Our voice mail system is checked every 60-90 minutes. This is sufficient for a psychiatry office. If you have a medical emergency please direct your call to 911 or go to the nearest emergency room for medical help. We are not able to deal with medical emergencies here in the office or on the phone.

If you or a family member feels suicidal, despondent, out of control or otherwise, you will be instructed to go to the emergency room for evaluation.

Refills on prescription medications from patients and/or pharmacies by phone and fax will be handled in a 24 to 48 hour time frame. Please do not wait until you are out of medication to call the office. If there is an urgent situation we will handle it but not on a regular basis. No refills will be given over the phone.

Patients on controlled medications, any refills deemed appropriate will be given to you at your office visit or e-scribed - with post dated prescriptions to be handed to the pharmacist. If you have run out of refills, an appointment is required. No refills will be given over the phone if you have not been seen in 3 months.

Thank you for understanding during our practice growth.

Dr. Larice & Staff

PATIENT 'S ACKNOWLEDGEMENT OF TELEPHONE POLICY: _____

INITIALS

Rolando Larice, MD

PHARMACY & MEDICATION

'Escribing' Medications (Electronically Sent to Pharmacy) – Since the majority of our medications are 'e-scribed' directly over to your Pharmacy, we require each patient to pick the Pharmacy that they want their medications to be filled at.

If you need to change Pharmacies for any reason, YOU MUST LET THE OFFICE KNOW BEFORE YOUR APPOINTMENT! We have to change in the computer for your medications to be sent correctly. If you do not let the office know there has been a change, you will have to pick up your medication at the Pharmacy that you last provided office.

Pharmacy Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

CURRENT MEDICATION LIST:

Name of Medication	Dosage	How Many Times a Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____