TAMPA BAY

PSYCHIATRIC SERVICES, PL

Boguslaw Gluszak, MD

3848 Flatiron Loop, Suite 102
Wesley Chapel FL 33544
Tel: 813 699 4020
Fax: 813 464 7682

Mailing Address:
1767 Lakewood Ranch Blvd. # 255
Bradenton FL 34211

www.tampabaypsychiatricservices.com

Date: _____

PATIENT INFORMATION

Patients Last Name _____First _____ _____MI _____

DOB_____ Age_____ Sex: M__ F__ Other_____

Address_____

City_____ State _____Zip Code_____

Home Phone #_____ Cell Phone for Text reminders_____

E-mail address:_____

Minor Patients:

Mother/Guardian: _____ tel: _____ e-mail_____ _____

Father /Guardian: _____tel:_ _____ e-mail_____ _____

Primary Care Physician: _____Tel: _____

Address: _____

Therapist: _____Tel: _____

Pharmacy Name:_____ Tel No: _____

Pharmacy Address:_____

How were you referred to this office:_____

PATIENT HISTORY FORM

LAST NAME _____ FIRST NAME: _____ DOB: _____ DATE _____

Review of Systems (2 pages)

Circle **Yes** or **No.**

General Symptoms	NOW		PAST		(Comments)
Weight change	Y	N	Y	N	
Chills	Y	N	Y	N	
Sleep Disorder	Y	N	Y	N	
Other					

Eyes					
Double vision	Y	N	Y	N	
Glaucoma	Y	N	Y	N	
Cataracts	Y	N	Y	N	
Other					

Ear/Nose/Throat/Mouth					
Hearing changes	Y	N	Y	N	
Sore throat	Y	N	Y	N	
Sinus problem	Y	N	Y	N	
Other					

Cardiovascular					
Chest pain	Y	N	Y	N	
Irregular heartbeat	Y	N	Y	N	
Swelling in ankles	Y	N	Y	N	
Other					

Psychologic					
Are you generally happy?	Y	N	Y	N	
Do you feel depressed?	Y	N	Y	N	
Do you feel anxious?	Y	N	Y	N	
Do you feel safe in your home?	Y	N	Y	N	

Endocrine					
Excessive thirst	Y	N	Y	N	
Too hot/cold	Y	N	Y	N	
Tired/sluggish	Y	N	Y	N	
Other					

Hematologic/Lymphatic					
Swollen glands	Y	N	Y	N	
Blood clotting problem	Y	N	Y	N	
Bruising	Y	N	Y	N	
Other					

Allergic/Immune					
Hay Fever	Y	N	Y	N	
Drug allergies	Y	N	Y	N	
Food	Y	N	Y	N	
Other					

Genitourinary	NOW		PAST		(Comments)
Change in stream	Y	N	Y	N	
Nocturia (getting up at night)	Y	N	Y	N	
Urinary frequency > 8 times/day	Y	N	Y	N	
Other					

Musculoskeletal					
Bone pain	Y	N	Y	N	
Muscle pain	Y	N	Y	N	
Joint pain	Y	N	Y	N	
Other					

Skin					
Rash	Y	N	Y	N	
Lumps or bumps	Y	N	Y	N	
Moles, skin tags	Y	N	Y	N	
Other					

Neurological					
Tremors	Y	N	Y	N	
Dizzy spells	Y	N	Y	N	
Numbness/tingling	Y	N	Y	N	
Other					

Respiratory					
Wheezing	Y	N	Y	N	
Frequent cough	Y	N	Y	N	
Shortness of breath	Y	N	Y	N	
Other					

Gastrointestinal					
Abdominal pain	Y	N	Y	N	
Nausea/vomiting	Y	N	Y	N	
Indigestion/heartburn	Y	N	Y	N	
Other					

Sexual History		
Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N
Other (i.e. sexual trauma)		

Last Exams or Lab tests: Please enter date (mo/yr)

Dental: _____	Eye : _____
Pelvic: _____	PAP smear: _____
Mammogram: _____	Cholesterol: _____
Colonoscopy: _____	Stool Tested: _____
Prostate _____	PSA test: _____

Living Will? ☐ Yes ☐ No Advanced Directive? ☐ Yes ☐ No Doctor's signature: _____

(Please Complete Other Side)

Medical History

Medical ☐ None (*High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.*)

Pregnancy History

Year	Sex	Complications

Surgical ☐ *None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc* - Please enter year surgery was done if known*)*

Allergies to medications? ☐ None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Last Immunizations: FLU ___/___/___ PNEU___/____/___ Tetanus ___/___/___ Other _____ ___/____/___

Current prescription medicines: ☐ **None**

Name of drug	mg dose	# tablets	# times per day

Additional current prescription medicines:

Name of drug	mg dose	# tablets	# times per day

Current Non-Prescription Medicine (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins, anti-acids, herbals.)

Family History

Father: ☐ Living - Age: _____ ☐ Deceased, Age at Death_____ (Cause) _____
Mother: ☐ Living - Age: _____ ☐ Deceased, Age at Death_____ (Cause) _____
Siblings: Number Living _____ Number deceased _____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon, breast, or prostate cancer, arthritis, depression etc)

(Family Member) (Illness) (Family Member) (Illness) (Family Member) (Illness)

_____= _____ _____ = _____ _____= _____

Social History

Caffeine ☐ Yes ☐ No If yes, how much? _____
Smoke? ☐ Yes ☐ No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? _____
Alcohol? ☐ Yes ☐ No If yes, how much? _____

Occupation. _____ ☐ Retired Significant prior industrial or agricultural exposures? ☐ Yes ☐ No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Number of children** _____ ☐ None

Exercise regularly? ☐ Yes ☐ No If yes, what and how frequently?

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Consent for Treatment

I, the undersigned, do hereby consent to participate in the Tampa Bay Psychiatric Service, PL Assessment Process and if I so choose, subsequent treatment if recommended. I understand that the Assessment is a collaborative effort between my family (if indicated), other professionals or healthcare providers, Tampa Bay Psychiatric Service, PL staff and myself to determine a diagnosis and treatment recommendations. Participation in the Assessment process does not constitute a treatment contract with Tampa Bay Psychiatric Service, PL to assume responsibility for my medical / psychiatric care.

_____

Signature **Date**

Financial Responsibility Consent

I, the undersigned have read and agree to the _Tampa Bay Psychiatric Services, PL fee policy. I acknowledge full financial responsibility for services rendered by TBPS. I further authorize Tampa Bay Psychiatric Services, PL to release all necessary medical information to my insurance company if requested. I authorize the use of this signature on all my insurance submissions. Although Tampa Bay Psychiatric Services, PL does not accept insurance anymore, sometimes we may have to share information with your insurance, ex: providing prior authorization information to the insurance to get your medication approved.

I also authorize Tampa Bay Psychiatric Services, PL to charge this credit card for any payments due for my virtual appointments.

_____

Signature of Insured / Guardian **Date**

_____

Address (if different than patient's)

Credit Card information:

Credit card: Visa _____ Master Card_____ Discover _____ Am. Express_____

Name on the card:_____

Card number _____

Expiration date _____Security code _____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

I understand that, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain right to privacy in regards to my protected health information (PHI).
I have received, read and understood The Notice of Privacy Practices.
The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Patient Name: _____ DOB: _____

Patient Signature _____Date_____

Patient's Parent/Guardian Signature: _____

Printed Name _____

Relationship to the Patient _____

I was unable to obtain the patient's signature
Date_____
Reason_____
_____
_____

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REFILL POLICY

If you need a refill, please CALL THE OFFICE, not pharmacy.

We do not respond to the refill requests coming from the pharmacy.

Refilling medication through pharmacies can be very frustrating and time consuming. It is our policy to give enough medication and refills to get you through to your next appointment. Please schedule appointments prior to your last dose of your last refill and do not wait until your medication runs out.

- Medications are refilled during medication follow up appointment. Please have a list of all prescriptions that require refill at your appointment. You will be provided with enough refills until your next visit.
- There are no refills without appointment on new medications/new dosages.
- You must have your next appointment on schedule in order to get prescription refill.
- If you require refill due to the missed appointment, there will be $25 charge.

Please allow **48 business hours** to process the request.

Prescriptions refills are done during regular business hours
(Mon-Fri 8 am – 6 pm)

Dr Gluszak reserves the right to refuse refilling any medication if he believes it is clinically necessary to evaluate patient before prescribing medication.

I have read and accepted the above terms.

Patient Name:_____

Patient/Guardian'sSignature_____Date_____

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FEE SCHEDULE – March 2024

Self Paid fees:

Psychiatric Evaluation, M.D,	**$300**
Follow up, 15-20 minutes,M.D.	**$120**
Follow up/Ind. Therapy, M.D.	**$200**

Please note that time scheduled for your appointment is reserved only for you. We do not offer that time to anybody else. If you have conflict in your schedule, please call the office to re-schedule as soon as possible.

No Show Fees:

No Show / Late Cancellation, Medication Management appt – $120
No show / No call 1 hr Therapy, M.D. - $200 (full cost)

First appointment deposit $100
48 hrs advanced notice is required for cancellations

Documentation: - $15 /page:
(for example: letters, disability questionnaires, life insurance questionnaires, etc.)

Returned check - $30 (If requested, we will gladly hold checks until certain date)

Court Appearance and Legal Consultations - $300/hr

Medications are refilled ONLY during medication follow up appointment. Please check before the visit if you need refills for your medication, and let Dr Gluszak know at the appointment. You will be provided with enough refills until your next visit.

Dr Gluszak does not use "automatic" refill requests from the pharmacies. Taking psychiatric medications needs to be closely supervised and followed up with the physician on regular basis.
If you require refill due to the missed appointment there will be $25 refill charge.

I have read and accepted the above terms.
Patient Name:_____

Patient Signature_____Date_____

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Communication by Email and Text Authorization

Our office offers patient communication by email and text for administrative purposes (scheduling, insurance information, etc.). This form provides information about the risks of emails/texts, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email/text.

Communication by email/text has a number of risks, which include the following:

- Can be circulated, forwarded and stored in paper and electronic files
- Backup copies of emails may exist even if the file has been deleted
- Can be received by unintended recipients
- Can be intercepted, altered forwarded or used without authorization or detection
- Senders can easily type the wrong email address
- Can be used to introduce viruses into the computer system

How we will use email/text: We will email correspondence to new and established patients who are 18 years or older, or the legal representative of established patients. We use email to communicate only about non-sensitive and non-urgent issues. All emails to or from you will be made a part of your medical record. You have the same right of access to such emails as you do to the remainder of your medical record. Your email message may be forwarded to another office staff member as necessary for appropriate handling. We will not disclose your emails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permit uses of your health information and your rights regarding privacy matters.

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911. Do not email for urgent problems. If you have an urgent problem during regular business hours, please call our office or go to the nearest emergency room or urgent care facility. Emails should not be time-sensitive. While we try to respond to email messages daily, **it may take up to two working days** for us to respond to your message. Urgent messages or needs should be relayed to us by using regular telephone communication. If you have not heard back from us within two days, call our office to follow up if we have received your email.

I have elected to communicate with Dr. Boguslaw Gluszak and Tampa Bay Psychiatric Services, PL staff by email. I understand the risk of communicating by email, in particular the privacy risks explained in this form. I understand that they cannot guarantee the security and confidentiality of email communication. They cannot be responsible for messages that are received or delivered due to technical failure, or for disclosure of confidential information not caused by intentional misconduct. I understand that I may also communicate with the doctor and/or office by telephone or during a scheduled appointment, and that email is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information. I understand that I may revoke this consent at any time by informing the office in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

☐ I agree to use e-mail to communicate with TBPS, PL about administrative/scheduling issues

☐ I agree to use text to to communicate with TBPS, Pl about administrative/scheduling issues

☐ I agree to receive attachment files with lab results or other documents containing personal information from TBPS, PL if requested by me.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for email communication to and from Tampa Bay Psychiatric Services, PL.

_____ _____

Patient Name Email Address

_____ _____

Signature (Patient or Legal Guardian) Date

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PSYCHIATRIST/THERAPIST – PATIENT CONTRACT
OUTPATIENT SERVICES

Welcome to our practice.

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Psychiatric / Therapy Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the doctor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last from one to two sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.]

Professional Fee-for-Service Fees

Psychiatric Evaluation/Consultation with M.D. -$300
Psychotherapy and/or medication follow-up 50min with M.D. - $200
Psychotherapy and/or medication follow-up 15-20 min, with M.D. - $120

No show/late cancellation (20 min. apt) – full fee $120
No show/late cancellation (50 min therapy) full fee - $200

We are considered out of network for the insurance companies. If requested, we will provide you with detailed receipt for the charges.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding.]

Billing and Payments

Payment is due at the appointment time. You will be expected to pay for each session at the time it is held. We will keep your credit card on file in our secure system, and will charge it at the appointment time.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, your credit card on file may be charged for past dues fees, or I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

Contacting Me

I am often not immediately available by telephone. I will not answer the phone when I am with a client. When I am unavailable, you can leave message for me with our staff or on my voice mail [that I monitor frequently). I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In emergencies, please dial 911 or contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If I will not be available for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Professional Records

The laws and standards of my profession require that I keep treatment records.
You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Confidentiality

In general, the law protects the privacy of all communications between a client and a psychiatrist or therapist, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child [elderly person, or disabled person] is being abused, I must [may be required to] file a report with the appropriate state agency.

<I would do so with the client in the office.>

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police; or seeking hospitalization for you. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature: _____

Name Printed: _____

Date: _____

Original to file
Copy to client

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NOTICE OF PRIVACY PRACTICES

Privacy Officer: Boguslaw Gluszak, MD
Notice Effective Date: 1/01/2022

*****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.*****

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.
This notice will be followed by any health care professional authorized to enter information in your medical records. All employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment:
We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence with medications we prescribe for the treatment purpose.

For Payment:
We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations:
We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by Law enforcement agencies
- To avert a serious threat to public health and safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to legal proceeding
- To a coroner or medical examiner for identification of body
- In an inmate, to the correctional institution or law enforcement official
- As required by US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities

- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health Oversight activities
- Other public health activities

We may contact you to provide appointment reminders, information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and disclosures of Protected Health Information Requiring Your Written Authorization:
Other uses and disclosures of medical information not covered by this Notice or the Laws that apply to us will be made only with your written authorization. If you give us a written authorization to use or disclose the medical information about you, you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHT REGARDING YOUR MEDICAL INFORMATION

Complaints:
If you believe your privacy rights have been violated, you may file the complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing the complaint.

Right to Request Restriction:
You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations or to someone who is involved with or in your care or the payment for your care. We are not legally bound to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with the emergency treatment. To request restrictions you must submit your request in writing... In your request, you must tell us what information you want limited.

Right to Request Confidential Communication:
You have the right to request how we should send our communications to you about medical matters, and where you would like these communications sent. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted. We reserve the right to deny the request, if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy:
You have a right to inspect and copy medical information that may be used to make decisions about your care.
Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in civil, criminal or administrative action or proceeding and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your care, you must submit your decision in writing. If you request a copy of the information, we reserve the right to charge the fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to your medical information, you may request that denial be reviewed.

Right to a Paper Copy of This Request:
You have a right to a paper copy of this Notice at any time. Even if you agreed to receive this copy electronically, you are still entitled to a paper copy.

Right To Amend:
If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.
To request an amendment, your request must be submitted in writing. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement and any corresponding rebuttals will be kept on file and sent out with any future request for information pertaining to the appropriate portion of your records.

Changes to This Notice:
We reserve the right to change this notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date at the very beginning of the notice.