



PATIENT INFORMATION

(Please Use Dark Ink & Print Clearly)

MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
NAME: FIRST M.I. LAST SSN: (PARENT/GUARDIAN #, IF UNDER 18)
BIRTHDATE: / / MALE FEMALE HOME PHONE: MOBILE PHONE:
ADDRESS: CITY: STATE: ZIP CODE:
EMAIL ADDRESS: DRIVERS LIC.#:
PATIENT'S EMPLOYER (PARENTS, IF MINOR): WORK PHONE:
WORK ADDRESS: CITY: STATE: ZIP CODE:
SCHOOL/COLLEGE, IF PATIENT IS A STUDENT: CITY: STATE:
NAME OF SPOUSE (IF APPLICABLE): SPOUSES EMPLOYER'S PHONE:
CONTACT IN CASE OF AN EMERGENCY?: PHONE:
HOW WERE YOU REFERRED TO OUR OFFICE?: (IF FROM INTERNET PLEASE INDICATE WEBSITE)

RESPONSIBLE PARTY (Complete only if different from Patient)

PERSON RESPONSIBLE FOR ACCOUNT: RELATIONSHIP TO PATIENT:
ADDRESS: CITY: STATE: ZIP CODE:
SSN: BIRTHDATE: / / HOME PHONE: DRIVERS LIC.#:
EMPLOYER: WORK PHONE:
WORK ADDRESS: CITY: STATE: ZIP CODE:

INSURANCE INFORMATION - PRIMARY

NAME OF INSURED: RELATIONSHIP TO PATIENT:
SSN: BIRTHDATE: / / HOME PHONE: WORK PHONE:
ADDRESS: CITY: STATE: ZIP CODE:
EMPLOYER: ADDRESS: DATE EMPLOYED: / / MONTH YR
INSURANCE COMPANY: INS. PHONE #:
INS. CO. ADDRESS: CITY: STATE: ZIP CODE:
INSURED'S ID#: INSURED'S GROUP #:
HOW MUCH IS YOUR DEDUCTIBLE?: AMOUNT USED: MAXIMUM ANNUAL BENEFIT:
CO-PAYMENT AMOUNT: CO-INSURANCE %: IS PREAUTHORIZATION REQUIRED?: YES NO

INSURANCE INFORMATION - SECONDARY (If Applicable)

NAME OF INSURED: RELATIONSHIP TO PATIENT:
SSN: BIRTHDATE: / / HOME PHONE: WORK PHONE:
ADDRESS: CITY: STATE: ZIP CODE:
EMPLOYER: ADDRESS: DATE EMPLOYED: / / MONTH YR
INSURANCE COMPANY: INS. PHONE #:
INS. CO. ADDRESS: CITY: STATE: ZIP CODE:
INSURED'S ID#: INSURED'S GROUP #:
HOW MUCH IS YOUR DEDUCTIBLE?: AMOUNT USED: MAXIMUM ANNUAL BENEFIT:
CO-PAYMENT AMOUNT: CO-INSURANCE %: IS PREAUTHORIZATION REQUIRED?: YES NO

PLEASE PROVIDE YOUR ACCURATE

BILLING POLICIES/LATE CHARGES

- 1) BY SIGNING THIS, YOU ARE CONSENTING TO TREATMENT PROVIDED BY Dr. Amy D. Miller (PROVIDER). YOU MAY TERMINATE TREATMENT AT ANY TIME WITHOUT PENALTY. ANY CONCERNS REGARDING TREATMENT SHOULD BE DISCUSSED WITH THE PROVIDER.
- 2) **FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION OF A SCHEDULED APPOINTMENT IS REQUIRED.** IF CANCELLATION IS MADE AFTER THIS TIME IT WILL BE CONSIDERED A "FAILED APPOINTMENT" AND YOU WILL BE CHARGED FOR THE FULL SESSION TIME RESERVED FOR YOU. IN THE CASE OF AN EMERGENCY, DEATH IN THE FAMILY, HOSPITALIZATION, ILLNESS, ETC., PLEASE SPEAK WITH YOUR PROVIDER REGARDING PAYMENT. IT IS UNDERSTOOD THAT TIME HAS BEEN RESERVED FOR YOU AND THE LACK OF ADEQUATE NOTICE PREVENTS SUFFICIENT TIME TO SCHEDULE OTHER PATIENTS WHO MAY BE IN NEED. IT IS ALSO UNDERSTOOD THAT **YOUR INSURANCE COMPANY WILL NOT PAY FOR A FAILED APPOINTMENT AND THAT YOU WILL BE RESPONSIBLE FOR THE FULL FEE.**
- 3) THE UNDERSIGNED AGREES THAT IN CONSIDERATION OF THE SERVICES TO BE RENDERED TO THE PATIENT HE/SHE AGREES TO PAY THE PROVIDER IN ACCORDANCE WITH THE TERMS OUTLINED AND AT THE PROVIDER'S CURRENT RATES. CHANGES TO RATES WILL OCCUR FROM TIME TO TIME AND WILL BE POSTED PRIOR TO THE EFFECTIVE DATE OF THE RATE CHANGE.
- 4) PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF USING INSURANCE BENEFITS, IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO DETERMINE YOUR PORTION DUE. YOUR BALANCE DUE IS YOUR FULL RESPONSIBILITY. YOUR PROVIDER REMITS CLAIMS AND ACCEPTS PAYMENTS FROM INSURANCE COMPANIES AS A COURTESY ONLY (FOR ALL NON-CONTRACTED CARRIERS).
- 5) SHOULD THE ACCOUNT BE REFERRED TO AN AGENCY OR ATTORNEY FOR COLLECTION, THE UNDERSIGNED WILL PAY REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSE. THE UNDERSIGNED SHALL ALSO BE RESPONSIBLE FOR ALL INTEREST, AFTER 60 DAYS, AT THE RATE OF 1.5% MONTHLY (18.0% ANNUAL) OF THE UNPAID MONTHLY BALANCE.
- 6) IF FAILURE TO COMPLY WITH THESE OBLIGATIONS, EACH CONSENTS TO THE DISCLOSURE OF THEIR IDENTITY AND OTHER NECESSARY INFORMATION RELATING TO SERVICES RENDERED TO THE PATIENT, BY THE PROVIDER, TO ANY THIRD PARTIES, INCLUDING COLLECTION AGENCIES AND/OR LEGAL REPRESENTATIVES FOR THE PURPOSE OF ENFORCING THE PATIENT'S OR GUARANTOR'S OBLIGATIONS TO THE PROVIDER. SUCH DISCLOSURE OR REDISCLOSURE SHALL NOT BE DEEMED TO BE A BREACH OF THE PATIENT'S CONFIDENTIALITY BY THE PROVIDER.
- 7) BY PROVIDING YOUR EMAIL ADDRESS YOU AUTHORIZE YOUR PROVIDER & BILLING PERSONNEL TO SEND & RECEIVE EMAILS TO/FROM YOU. IF YOU DO **NOT** WANT ANY CORRESPONDENCE BY EMAIL PLEASE CHECK HERE.

SIGNATURE

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND AGREE TO THESE CONDITIONS.

X

DATE: / /

SIGNATURE OF PATIENT, OR GUARDIAN IF MINOR

AUTHORIZATION AND RELEASE

I AUTHORIZE Dr. Amy D. Miller (PROVIDER), IT'S AGENTS OR ASSIGNS, TO RELEASE ANY INFORMATION OF THE PATIENT, INCLUDING DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED, DURING THE PERIOD OF SUCH CARE, TO THE PROVIDER'S EMPLOYEES OR CONTRACTORS, THIRD PARTY BILLING AGENTS, THIRD PARTY PAYOR'S, OR OTHER SUCH PARTIES NECESSARY FOR THE PURPOSE OF CLAIMS PROCESSING AND OBTAINING PAYMENT FOR SERVICES RENDERED TO THE PATIENT.

I AUTHORIZE AND REQUEST THAT MY INSURANCE COMPANY PAY DIRECTLY TO Dr. Amy D. Miller (PROVIDER) INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER ACKNOWLEDGE AND AGREE THAT MY SIGNATURE AUTHORIZES THE PROVIDER, OR THE PROVIDER'S EMPLOYEES OR AGENTS, TO SUBMIT CLAIMS AND OTHER REQUESTS FOR PAYMENT ON MY BEHALF OR MY DEPENDENTS.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X

DATE: / /

SIGNATURE OF PATIENT, OR GUARDIAN IF MINOR



DR. AMY D. MILLER & ASSOCIATES, LTD.

Welcome to our office; Please complete the following:

Date _____

Name: _____ Social Security # _____ (Required)

Height _____ ft _____ Inches Weight _____ lbs Date of Birth _____

Marital Status (check one) Single Engaged Married (how long? _____) Separated Divorced
 Widowed Remarried (how many times? _____) Living with someone

Children / Step Children

Name	Age	Relationship	Living at Home Y/N

Siblings

Gender (M/F)	Age

Parents Living? Y / N Adopted? Y / N

Name of family physician (N/A if none) _____ Phone# _____

Name of psychiatrist (N/A if none) _____ Phone# _____

DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your problem(s) _____

Please estimate the severity of your problems on the the following scale:

Mildly upsetting Moderately upsetting Very severe Extremely severe Totally incapacitating

When did the problem(s) begin (give dates) _____

Please describe significant event(s) occurring at that time, or since then, which may relate to the development or maintenance of the problem(s) _____

What solution to your problem(s) have been most helpful? _____

Have you been in psychotherapy before or received any prior professional assistance for the problem(s)? If so, please give name(s), professional title(s), dates of treatment and results _____

Your expectations regarding psychotherapy _____

In general, what do you think psychotherapy is all about? _____

How long do you think your therapy should last? _____

Check any of the following behaviors that apply to you:

- | | | | | |
|-----------------------------------|--|---|--|---|
| <input type="checkbox"/> Overeat | <input type="checkbox"/> Impulsive reactions | <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Take too many risks | <input type="checkbox"/> Nervous tics |
| <input type="checkbox"/> Smoke | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Take Drugs |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Outbursts of temper | <input type="checkbox"/> Odd behavior | <input type="checkbox"/> Work too hard | <input type="checkbox"/> Loss of control |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Drink too much | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Can't keep a job |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Phobic avoidance | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Panic attacks |
| | | | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Procrastination |

Are there any specific behaviors, actions, or habits that you would like to change? _____

What are some specific talents or skills that you feel proud of? _____

What would you like to do more of? _____

What would you like to do less of? _____

What would you like to start doing? _____

What would you like to stop doing? _____

How is your free time spent? _____

Do you keep yourself compulsively busy doing an endless list of chores or meaningless activities? _____

Do you practice relaxation or meditation exercises regularly? _____

PHYSICAL SENSATIONS

Check any of the following that often apply to you

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tingling | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Hear things | <input type="checkbox"/> Don't like to be touched |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Flushes | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Tics | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Sexual disturbances | <input type="checkbox"/> Twitches | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Burning or itchy skin | |
| <input type="checkbox"/> Bowel disturbances | <input type="checkbox"/> Tremors | <input type="checkbox"/> Chest Pain | |

What sensations are especially:

Pleasant for you? _____

Unpleasant for you? _____

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Please specify _____

Please list any medicine(s) you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicine(s) that were prescribed or taken over the counter) _____



Dr. Amy D. Miller & Associates, Ltd.

Patient Instructions

Please complete by signing and dating the **Patient's Acknowledgement** section below. Retain the **NOTICE OF PRIVACY POLICY** for your records.

RETURN ONLY THIS PAGE TO OUR OFFICE

Patient's Acknowledgement

I hereby acknowledge that I have been provided with the practice's **NOTICE OF PRIVACY POLICY** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name

Signature of Patient (or Legal Guardian/Representative)

Date

Witness Name

Signature of Witness

Date

April 13, 2003 .
Notice Effective Date (See Page 1)



Dr. Amy D. Miller & Associates, Ltd.

Office Copy

Thank you for being our patient

In order to give you a better understanding of our services & procedures, we would like to provide you with the following information.

- An hour session is based on a "clinical hour" in accordance with the Healthcare & Insurance industry. A clinical hour is between 45-50 minutes.
- Dr. Miller uses an outside billing service. If, however, you should have any questions regarding your statement, please contact Dr. Miller. If she is unable to assist you, she will contact the billing service directly. You may also contact a billing representative directly via email at **Billing@DrAmyMiller.com**. All emails sent to this address will be automatically forwarded to the billing company.
- Our office accepts payments from insurance companies as a courtesy to our patients. Please note that you are fully responsible for all charges and **it is your responsibility to contact your insurance company to verify benefits, eligibility & coverage**. Some insurance companies require preauthorization for behavioral health benefits prior to receiving any treatment. **Please check with your insurance company prior to your initial appointment and obtain an authorization if necessary**. Failure could result in a loss of insurance benefits.
- If you should change insurance carriers or have any other changes to your insurance, it is important that your clinician is notified of this change promptly & that your new insurance information is provided. Also, a copy (front & back) of your new or revised insurance card should be provided to our office promptly.
- We try to be understanding of our patient's busy schedules and lifestyles. Please note, however, that **your clinician must receive (48) hours notice of cancellation or appointment change**. Please understand that this time has been reserved for you. The lack of adequate notice prevents sufficient time to schedule other patients in need. Notice within (48) hours will be considered a "Failed" appointment. **Failed appointments are not eligible for insurance benefits and you will be responsible for payment in full**. Please discuss emergency situations with your clinician directly.
- Your appointment time slot has been reserved for you. If you arrive to your appointment late, please understand that your full session time generally cannot be provided. Abiding to the set schedule as arranged prevents disturbance to following appointments.
- Co-payments are due at the time of service. It is your responsibility to contact your insurance company to determine your portion due. Any amount due at the time of service is expected to be paid. Self payers (patients without insurance or not utilizing insurance) are responsible for paying their full session fee at the time of service.

Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: ____/____/____



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- Our office accepts payments from insurance companies as a courtesy to our patients. Please note that you are fully responsible for all charges and **it is your responsibility to contact your insurance company to verify benefits, eligibility & coverage**. Some insurance companies require preauthorization for behavioral health benefits prior to receiving any treatment. **Please check with your insurance company prior to your initial appointment and obtain an authorization if necessary**. Failure could result in a loss of insurance benefits.
- If you should change insurance carriers or have any other changes to your insurance, it is important that your clinician is notified of this change promptly & that your new insurance information is provided. Also, a copy (front & back) of your new or revised insurance card should be provided to our office promptly.
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