Confidential Child Patient Information

Revel Miller, Ph.D.

Please answer all questions as completely as possible. If a question does not apply to you, simply leave it blank. Please print or write clearly. Thank you!

Primary Custodial Parent Information

Name & Age of Primary Parent/Guardian:____

Name & Age of Step-Parent:____

Home Address:____

Preferred Mailing Address:____

Preferred Email Address:______________________ Child's Birth Place:_________________

Phones that we are permitted to call and leave messages at: Home:____________________
Office:_________________ Cell:_________________

Marital Status: □ Married □ Co-Habitating □ Single □ Separated □ Divorced □ Widowed

Name/Age of Spouse/Partner:_________________ Number & Ages of Children at Home:_____

Employer:___________________________ Occupation:_______________________________

Emergency Contact:___________________ Relationship:_________ Phone:_______________

Highest Level of Education Completed:____

Physical Health: □ Excellent □ Good □ Fair □ Poor

Current or Chronic Health Problems:____

Current Medications & Dosages:____

Primary Medical Doctor:________________________ Date of Last Exam:________________

Referred By:____________________________ May I thank them for your referral? □ Yes □ No

Child Information

Name of Child:________________________ Date of Birth: ___________ Age:____

Gender: M or F Place of Birth:_____________ School:____________________ Grade:____

Teacher:___________________ School Performance: □ Outstanding □ Average □ Poor

Physical Health: □ Excellent □ Good □ Fair □ Poor

Primary Medical Doctor:________________________ Date of Last Exam:__________________

Previous Therapist:_______________________ City:__________________ Dates:____ to ____

Previous Therapist:_______________________ City:__________________ Dates:____ to ____

Brief Description of Problem

Why are you seeking help for your child now? What are the current problems or concerns?

____

____

Describe your relationship with your child:____

Estimate the severity of the problem(s) presented: □ Mild □ Moderate □ Serious □ Severe

Any serious suicidal or homicidal ideas, plans or actions in the past 30 days? □ No □ Yes

Describe child's strengths/talents/hobbies:____

Child Health Insurance Information

As a licensed psychologist, I am not a service provider for any insurance companies and I do not accept payment from health insurance providers. However, if you grant me permission to send claims to your provider, we will do so on a monthly basis. Then the policy holder may receive a reimbursement check directly from your provider. They do not send checks to me.

Insured Person's Name/Policy Holder:______________________ Telephone #:___________

Relationship to Child Patient:______________________

Insured's Mailing Address:____

Insurance Company Name:____________________ ID Number:___________ Group#:_____

Telephone #:___________ Claims Address:____

Four Agreements

1) **Payment:** I hereby agree to pay Dr. Revel Miller directly for all services rendered.
2) **Insurance:** I give Dr. Revel Miller permission to release information required to process my child's insurance claims with his/her health insurance provider.
3) **Consent for Treatment:** I authorize Dr. Revel Miller to carry out psychological assessments, treatments and/or diagnostic procedures with my child as his patient. I understand that these procedures will be explained to me and subject to my agreement.
4) **This Information Form:** I have read and fully understand all the above information and agreements contained in this Confidential Child Patient Information form.

____________________________ ______________________________ ___/___/______

Primary Parent's Printed Name Primary Parent's Signature Date

***PLEASE NOTE*: Refer to Dr. Miller's Policies and Procedures Agreement for more in-depth details about confidentiality exceptions, treatment process & planning, insurance, communications, fees, payment, missed appointments, patient rights, etc.**