Confidential Adult Client 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 Read and Complete All 3 Pages*** *and* print or write very clearly. Thank you!

Personal Information Today's Date:____________________

Name:______________________________ Date of Birth: _____________ Age:______

Gender:___________ Place of Childhood Upbringing:__________________ Education Level:_______

Home Address:____

Preferred Mailing Address:____

Phones and Email that we are permitted to call and leave/send messages: Home:_________________

Office:__________________ Cell:__________________ Email:_________________________________

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

Name of Spouse/Significant Other:__________________________ Age of Children:________________

Employer:_____________________________________ Occupation:______________________________

Gross Annual Household Income: $______ Emergency Contact:______________ Phone:___________

Referred By:_______________________________ May I thank them for your referral? ☐ Yes ☐ No

Health Insurance Information (***Please PRINT clearly*** so I can easily read all your insurance information)

As a licensed psychologist, I am only "in-network" with Medicare. If you are a Medicare subscriber, then I will submit a monthly claim to Medicare and I will wait for reimbursement. Only your Medicare copay is due at the time of service if your annual deductible amount has been satisfied. If your annual deductible obligations are not met, then you are responsible to pay my full fee at the time of service. Medicare automatically passes-on claims to your secondary gap insurance.
If I am not a provider with your insurance company, then I can submit a monthly claim to your insurance provider and you must pay me at the time of service. They may reimburse you for my services.
If you don't use health insurance to pay for my services, then you must pay me at the time of service. Payments are made by check, cash or credit/debit card at the time of service.

Ultimately, you, the client, are responsible for all payments if your insurance company denies payment on claims for any reason. Late charges and collection agencies may be required for late payment.

Insured Person's/Policy Holder Name:___________________________ Relationship to You:_________

Your Full Name:__________________________ Your Social Security Number:______-_____-_______

Insured's Full Mailing Address:____

Insurance Company Name:____________________________ Insurance Phone #:_________________

Insurance Policy ID Number:_________________________________ Group#:____________________

Secondary Insurance Name:___________________________ Insurance Phone #:_________________

Secondary Insurance ID Number:______________________________ Group#:____________________

(For Office Use Only) ICD-10 DX:

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Previous Psychotherapy Treatment Outcome: ☐ satisfied ☐ somewhat satisfied ☐ not satisfied

Therapist:___________________________ City:_____________________ Dates:_______ to _______

Health Information Current Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current or Chronic Health Problems:____

Current Medications & Dosages:____

Primary Medical Doctor:______________________________ Date of Last Exam:_________________

Brief Description of Problem Why seek help now? List current problems, concerns or goals.

____

____

Type of Psychotherapy I am seeking: ☐ Individual ☐ Couples ☐ Group ☐ Family

Type of Consultation I am seeking: ☐ Parenting ☐ Separation/Divorce ☐ Caregiver ☐ Coaching

Estimated severity of the problem(s) presented: ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

Estimate your motivation to change: ☐ Little ☐ Moderate ☐ Serious ☐ Highly Motivated

Any serious suicidal or homicidal ideas, plans or actions in the past 60 days? ☐ No ☐ Yes

List your personal strengths/talents/hobbies:_______________________________________

____

Five Agreements:

1) **Payment:** Ultimately, I am responsible to pay Dr. Revel Miller for his time and services. I will also pay full fee of $180 for my “no shows” and “late cancellations” for individual and couples therapy with less than one full business day advance notice by phone to Dr. Miller.
2) **Insurance:** I give Dr. Revel Miller permission to release information required to process my insurance claims from Dr. Miller’s billing service to my health insurance provider.
3) **Privacy Practices:** Dr. Miller has given me a written copy of the HIPAA Privacy Rules for the Protection of Health and Mental Health Information for me to read.
4) **Consent for Treatment:** I authorize and request Dr. Revel Miller to carry out psychological assessments and treatment as his client. I understand that these procedures will be explained to me and subject to my agreement.
5) **This Information Form:** I have read and fully understand all the above information and agreements contained in this Confidential Adult Client Information form.

______________________________ ________________________________ ______/______/______

Client’s Printed Name Client Signature Date

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***PLEASE NOTE*:**

Refer to my Policies and Procedures Agreement for more in-depth details about confidentiality exceptions, treatment process & planning, insurance, communications, fees, payment, missed appointments, etc.

Please be advised that although I am in an independent private practitioner I also utilize a *HIPAA compliant Billing Service/Agent and Collection Company. My Billing Agents will have access to your **PHI (person information) that is directly related to billing or collections.

Unless otherwise notified in writing, I have your consent to give your information to my confidential billing service and to share your treatment information with your insurance company. You have the right to revoke your consent at any time.

Please let me know if you have any questions or concerns about the insurance billing processes.

*The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**Protected Health Information (PHI), which is generally individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to: 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information.

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