Confidential Child 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 clearly. Thank you!

Child Information Today's Date:__________________

Full Name of Child:_________________________________ Date of Birth: ___________ Age:______

Gender:_________ Place of Birth:________________ School:______________________ Grade:____

Child Cell Phone:___________________ School Performance: □ Outstanding □ Average □ Poor

Physical Health: □ Excellent □ Good □ Fair □ Poor Problem:______________________________

Primary Medical Doctor:______________________________ Date of Last Exam:________________

Current Medications & Dosages:____

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

Brief Description of Problem

Why are you seeking help for your child now? What are your 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 60 days? □ No □ Yes

Describe child's strengths/talents/hobbies:____

Primary Custodial Parent Information

Full Name & Age of Primary Parent(s)/Guardian(s):____

Full Name & Age of Step-Parent:____

Full Home Address:____

Preferred Mailing Address:____

Parent Preferred Email Address:____

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

Office:______________________________ Mobile:_________________________________

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

Name & Ages of Other Children at Home:____

(For Office Use Only) ICD-10 DX:

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Employer:___________________________________ Occupation:__________________________

Emergency Contact:______________________ Relationship:__________ Phone:________________

Highest Level of Education:________________ Gross Annual Combined Parent Income: $__________

Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current or Chronic Health Problems:____

Current Medications:____

Primary Medical Doctor:_____________________________ Date of Last Exam:__________________

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

Child Health Insurance Information

As a licensed psychologist, I am <u>not</u> currently “in-network” with any insurance companies other than Medicare. Although I am not a provider with your child’s insurance company, I can still submit a monthly reimbursement claim to your child’s insurance provider. They may reimburse you for my services.

The accompanying parent must pay my fee at the time of service. Payments are made by check, cash or credit/debit card. Late charges and collection agencies may be required for late payment.

<u>Five Agreements</u>

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

_____________________________ ________________________________ ____/____/_______

Primary Parent’s Printed Name Primary Parent’s 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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