

# Confidential Adult Client Information

Revel Miller, Ph.D.

**Please Read and Complete All 3 Pages and Print or Write Clearly.** Thank you!

## **Personal Information**

Today's Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

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-Habiting  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 & Payment for Services**

**If you have no insurance coverage**, then you must pay me in full at the time of service.

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. If your annual Medicare deductible amount has not been met yet (about \$185 per year), then you need to pay my fee until the annual Medicare deductible is met. The authorized Medicare co-payment fee (\$27) is due if you do not have secondary back-up insurance. Any over-payments to me will be refunded.

I am “out-of-network” with all other health insurance companies. If you subscribe to another insurance company, then you must pay my fee in full at the time of service. I will send in monthly claims to your insurance company after your annual deductible is met as long as they reimburse you.

**(Please PRINT clearly so I can easily read your insurance information.)**

Insured Person's/Policy Holder Name: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_\_ Your Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Full Mailing Address: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Insurance Policy ID Number: \_\_\_\_\_ Group#: \_\_\_\_\_

Annual Deductible Amount: \_\_\_\_\_ Anniversary Date: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Secondary Insurance ID Number: \_\_\_\_\_ Group#: \_\_\_\_\_

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**Payments are made by check, cash or credit card at the time of service.** A \$5 charge will be added to my fee when using credit cards in order to cover the card service fee.

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

**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/hobbies: \_\_\_\_\_

**Six Agreements:**

- 1) **Payment:** Ultimately, I am responsible to pay Dr. Revel Miller for his time and services.
- 2) **Late Cancellations and No Shows:** I will pay \$150 for my “no shows” and “late cancellations” for scheduled sessions with less than one full business day advance notice by phone to Dr. Miller (805-448-5053).
- 3) **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.
- 4) **Privacy Practices:** Dr. Miller has offered me a written copy of the HIPAA Privacy Rules for the Protection of Health and Mental Health Information for me to read.
- 5) **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.
- 6) **This Information Form:** I have read and fully understand all of 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: Health Insurance Billing Information**

Please be advised that although I am 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 (Personal Health 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 Dr. Miller 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.

**Dr. Miller's Office Location:**  
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