Confidential Child Client Information

Revel Miller, Ph.D.

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:_____ Child Phone:_____

School:_____ Grade:___ Child Email:_____

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:_____

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:_____

Parent Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

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Gross Annual 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 & Payment for Services

If you are not using insurance coverage, then you must pay me in full at the time of service.

As a licensed psychologist, **I am not currently "in-network"** with any insurance companies other than Medicare. Although I may not be a provider with your child's insurance company, I can still submit a monthly reimbursement claim to your child's insurance provider after his/her annual deductible is met as long as they reimburse you.

Full Name of Subscriber Parent: _____ Date of Birth: _____

Subscriber's Address & Phone:_____

Name of Insurance Company: _____ ID #: _____

Group #: _____ Annual Deductible Amount: _____ Anniversary Date: _____

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 parent, 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.

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 the insurance claims from Dr. Miller's billing service to my child's 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 assessment and treatment with my child 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 Child Client Information 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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