

**Miller Counseling & Associates, Inc.**  
**630-324-8298**

**Demographic Information:**

**Whom can we thank for referring you to us?**

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_ Client DOB \_\_\_\_\_

**Policy Holder/Insurance Information:**

Insured Name \_\_\_\_\_ Relationship to Client \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ PPO or HMO

Member or ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Phone # (back of card) \_\_\_\_\_

Vehicle Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Plate # \_\_\_\_\_

As of this date, the information above is accurate, and I have provided Miller Counseling & Associates, Inc. a copy of my insurance card (if applicable). I know that it is my responsibility to notify the office of any changes in insurance coverage, and that failure to do so, will result in me being held responsible for any uncovered charges. I further understand that benefit quotes given by my insurance carrier are considered estimates, and that they may not accurately reflect my benefit allowance. It is my responsibility to routinely review the explanation of benefits provided to me by my insurance carrier, and to notify Miller Counseling & Associates, Inc. of any discrepancies.

Signature of Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_



What medications are you currently taking? (Please include over the counter medications).

| Medication | Dose/Frequency | For What Condition? | MD |
|------------|----------------|---------------------|----|
| 1.         |                |                     |    |
| 2.         |                |                     |    |
| 3.         |                |                     |    |
| 4.         |                |                     |    |
| 5.         |                |                     |    |
| 6.         |                |                     |    |

Please mark any symptoms you are currently experiencing. (Indicate with a “C” if the symptom is current and with a “P” if you have had the symptom in the past.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Alcoholism                           | <input type="checkbox"/> Unexplained/Chronic Pain     |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Drug Addiction                       | <input type="checkbox"/> Trouble Sleeping             |
| <input type="checkbox"/> Fainting Spells      | <input type="checkbox"/> Compulsive Behaviors                 | <input type="checkbox"/> Sleeping Too Much            |
| <input type="checkbox"/> Fast Heartbeat       | <input type="checkbox"/> Obsessive Thoughts                   | <input type="checkbox"/> Can't Make Decisions         |
| <input type="checkbox"/> Stomach Trouble      | <input type="checkbox"/> Gambling Too Much                    | <input type="checkbox"/> Poor Concentration           |
| <input type="checkbox"/> Irritable Bowel      | <input type="checkbox"/> Shopping Too Much                    | <input type="checkbox"/> Constantly Worried           |
| <input type="checkbox"/> Eating Concerns      | <input type="checkbox"/> Viewing Internet Porn                | <input type="checkbox"/> Feeling Ashamed              |
| <input type="checkbox"/> Poor Appetite        | <input type="checkbox"/> Shoplifting                          | <input type="checkbox"/> Feeling Inferior             |
| <input type="checkbox"/> Increased Appetite   | <input type="checkbox"/> Cutting/Injuring Yourself            | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Recent Weight Change | <input type="checkbox"/> Sexual Problems/Concerns             | <input type="checkbox"/> Suicidal Thoughts            |
| <input type="checkbox"/> Hyperventilation     | <input type="checkbox"/> Frequent High Risk Sexual Encounters | <input type="checkbox"/> Frequently Angry             |
| <input type="checkbox"/> Shyness              | <input type="checkbox"/> Sexual Abuse                         | <input type="checkbox"/> Don't Enjoy Things I Used To |
| <input type="checkbox"/> Fatigue/Tiredness    | <input type="checkbox"/> Sexual Identity Concerns             | <input type="checkbox"/> Racing Thoughts              |
| <input type="checkbox"/> Tenseness            | <input type="checkbox"/> Sexual Orientation Concerns          | <input type="checkbox"/> Hearing Voices               |
| <input type="checkbox"/> Can't Relax          |   | <input type="checkbox"/> Hearing Difficulty           |
| <input type="checkbox"/> Feeling Panicky      |   | <input type="checkbox"/> Physical Abuse               |
| <input type="checkbox"/> Financial concerns   |   |   |

What other health information do you think we should know about (including past medications, hospitalizations, treatment and symptoms)?

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**Communication Consent:**

**HIPPA** is the acronym for the Health insurance Portability and Accountability Act of 1996. The Administrative Simplification of this act is a concern to us, and requires us to comply with specific rules regarding the following:

- Unique identifiers for health plans, providers, individuals and employers
- Healthcare transactions & code sets for transmitting electronic data
- Privacy regulations over the disclosure and use of health information
- Security regulation over protections of electronic health information

The policy of Miller Counseling & Associates, Inc. is not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, email, cell phone, and text or pager messages. This means that if we return a phone call, we will not leave a detailed message, unless we have your consent to do so.

I, \_\_\_\_\_, authorize Miller Counseling & Associates, Inc. to leave a detailed message, including reference to appointment times, and call back number on the following (please circle):

|                   |     |    |     |
|-------------------|-----|----|-----|
| Home Phone        | Yes | No | N/A |
| Answering Machine | Yes | No | N/A |
| Work Phone        | Yes | No | N/A |
| Voicemail         | Yes | No | N/A |
| Cell Phone        | Yes | No | N/A |
| Pager             | Yes | No | N/A |

I authorize the following individuals to have access to my treatment information:

|                      |     |    |     |
|----------------------|-----|----|-----|
| Spouse/Partner _____ | Yes | No | N/A |
| Parent(s) _____      | Yes | No | N/A |
| Other _____          | Yes | No | N/A |

**Email Communication:** Please note-email correspondence is not a secure mode of communication and it is possible that information transmitted via email can be accessed and read by unauthorized persons. We will only communicate via email with you, if you expressly authorize us to do so. We reserve the right to decline this mode of communication even if you provide authorization, if we have concerns about compromising any clinical information.

I authorize Miller Counseling & Associates, Inc. to communicate with me using email. Yes No

Email address: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Treatment:**

This is your therapy and you are the expert on your life. Our expertise is human behavior. We will work collaboratively with you to explore your thoughts, feelings, beliefs and behaviors, in order to assist you in seeing options/alternatives for change. We will work together at establishing goals, and routinely evaluate your progress, to ensure you are getting what you need and want. In signing this consent, you are stating that you understand that psychotherapy is not an exact science, and that change can be difficult. Outcomes are dependent on many factors, including the willingness of the client to initiate a different course of action in patterns of behavior or thought. In addition, at any time, it is your right to decline treatment recommendations. As your therapists, we welcome questions and input throughout this process.

I, \_\_\_\_\_, give my consent for services for myself or my child/legal dependent, \_\_\_\_\_, with Miller Counseling & Associates, Inc. including assessment, psychotherapy, testing (if indicated) and involvement in the treatment planning process.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Release of Information To/From Physician:**

**Pursuant to Law:** You are hereby informed that it s desirable for you to talk with your **primary care physician, or your child’s pediatrician**, regarding seeking mental health services. Below please indicate whether you give consent for me to provide this notification.

I, \_\_\_\_\_, give my consent to Miller Counseling & Associates, Inc. to discuss my condition, or that of my child/legal dependent, with my **primary care physician**, or in the case of a minor child, pediatrician. I also consent to the release of any medical documentation to/from my primary care physician for the purposes of treatment.

\_\_\_ Yes, I consent

\_\_\_ No, I do not consent

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Clint Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please take the time to review it carefully.**

The privacy of your medical information is important to us. The U.S. government established privacy rules, governing protected health information under the Health Information Portability & Accountability Act (HIPPA) of 1996. This notice tells you about how your medical information may be used and your rights.

**Use and Disclosure of Your protected Health Information (PHI):**

Federal law provides that we may use your PHI for treatment of you, without further specific notice to you, or written authorization by you.

Federal law provides that we may use your PHI to obtain payment for our services without further specific notice to you or written authorization by you. For example, under your health plan, we are required to provide them with a diagnostic code for your visit and a description of the services rendered.

Federal law provides that we may use your PHI for health care operation without further specific notice to you, or written authorization by you. For example, our accountant may see your name, dates of treatment, and procedure codes during an audit. We may use your information for financial services, quality assurance, risk reduction or claim management purposes with our medical professional liability insurer.

We may disclose or use your PHI without further notice to you, or specific authorization by you where:

1. Required by law
2. Required for public health services
3. Required by law to report child abuse
4. Required by oversight/regulatory entities such as the Department of Health, Office of Professional Discipline, or Office of Professional Medical Conduct
5. Required by law in judicial or administrative proceedings
6. Required by law enforcement purposes by a law enforcement official
7. Required by coroner or medical examiner
8. Permitted by law to a funeral director
9. Permitted by law to avert a serious threat to health and safety
10. Permitted by law and required by military authorities if you are a member of the U.S. Armed Forces.

*Other uses or disclosures of your PHI will only be made with your written authorization. You have the right to revoke any written authorization you give.*

**Use and Disclosure of PHI (Con't)**

*Rights You Have:*

You have a right to request restrictions of certain disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have a right to obtain and inspect copies of your PHI (a reasonable fee will be charged).

You have a right to request an accounting of disclosures we make of your PHI, except for:

- Disclosures we make to you
- Disclosures made to carry out treatment
- Disclosures permitted or required under 456 CFR 164.052
- Disclosures made to obtain payment or healthcare operations
- Disclosures for emergency notification purposes
- Disclosures for national Security or Intelligence purposes permitted by law
- Disclosures made by correctional facilities or law enforcement officials as permitted by law

*Obligations We Have:*

We are required by law to maintain the privacy of PHI and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all PHI we maintain. Any revised notice will be posted in our office, and copies made available.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us.

No retaliatory action will be made against you for any complaint you file.

I have received and I understand the notice regarding my Personal Health Information uses and disclosures:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Financial Policy:**

We are committed to your treatment being successful. Please understand that payment of your bill is considered to be your obligation, in exchange for our provision of services to you and your family. The following is a statement of our Financial Policy, which is required for you to read and sign prior to the start of treatment. If the client is a minor child, the parent(s), legal guardian, or when indicated, the custodial parent is responsible for signing.

### **1. Insurance and Payments:**

Your insurance policy is a contract between you and your insurance company. Miller Counseling & Associates, Inc. is not a party to that contract. Prior to your first session, we strongly encourage you to contact your insurance company and research the details of your benefits; how you can expect to obtain reimbursement, what percentage you can expect to receive, what conditions are covered, deductible amounts and any co-payment/co-insurance amounts that might apply.

#### **In-Network:**

We are a preferred provider for several insurance companies and if your insurance company is one in which we are a preferred provider, as a courtesy, we will process your claims for you. However, all co-payments, deductibles, and co-insurance amounts will be due at the time of service. **Deductibles have to be met on an annual basis before any benefits begin.**

#### **Out of Network or No Coverage:**

If you are uninsured, have chosen not to file with your insurance, or are a member of a plan in which we don't participate, *Full Payment is Due at the Time of Service*. For individuals with non-participating plans, we will provide you with monthly documentation upon request, including visit dates, diagnosis, etc., to support reimbursement by your insurance carrier. If you would like us to process your claims for you we will do so for a reasonable fee, and if applicable, not accept assignment of benefits and/or request insurance reimbursement is sent directly to you. As a non-participating provider, we do not honor any usual and customary discounts set by your insurance carrier.

#### **Payments:**

All payment can be made by check or in cash. If a credit or debit card is used, a processing fee will be added. All clients are required to have a valid credit card on file with us (form on back page). Returned checks will incur a \$50 fee, in addition to any bank charges imposed, and the full amount of the payment. If an account is overdue by 90 days or more, it will be subject to collections, and you will be responsible for interest charges on the account, as well as fees imposed by the collection agency. In the event that legal action is necessary to receive payment, you will be responsible for all charges incurred in the legal process, including, but not limited to, attorney fees, court costs, and time spent on collection efforts.



## **2. Cancellations, Failed, and Re-Scheduled Appointments:**

Please understand that when you make an appointment, we set aside that date and time specifically for you, and adjust our schedule, and other client times accordingly. If you need to cancel or reschedule an appointment, please call at least 24 hours in advance of the appointment. This allows us time to offer the appointment to a client who would otherwise have to wait to be seen. Cancellations with less than 24 hours notice, or failed appointments, will result in the full session fee being charged to your account. This will be reflected as "Failed Appointment" on your statements. Payments for failed appointments are due at the time of your next scheduled appointment or within 30 days, whichever comes first. Insurance companies do not reimburse for late cancellations or failed appointments; therefore, payment is your responsibility. If we must cancel or reschedule an appointment, or in the event that we miss an appointment, you will not be charged, and we will offer you a comparable appointment time.

## **3. Appointment Length/Late Arrivals:**

Appointment times are 45-60 minutes in duration, based on the length billable by insurance companies. We will make every effort to start and end sessions on time. The few minutes in between appointments allows us to return phone calls, perform needed documentation, consult with other health care professionals, etc, and ensures that we are timely in starting our next session. We ask that you respect this by coming to your scheduled appointment on time. If you find that you will be late for an appointment, please understand that we cannot provide you with the full amount of your appointment time, as it would cause a delay in responding to, or seeing other scheduled clients. We will be happy to meet you for the duration of time remaining, or you may reschedule. Rescheduling will be treated as a failed appointment, unless the appointment is cancelled with a minimum of 24 hours notice. If we are late for your appointment, you will be given your full appointment time, at the time of your session, or at another time of your convenience.

We are committed to you, and your success. If appointments are frequently cancelled, missed, or late in starting, we will discuss with you, your readiness and commitment to the therapeutic process.

## **4. Administrative Costs for Additional Ancillary Services:**

### **Phone Calls:**

We are available by phone or by email should you need to consult with us between sessions. There is no charge for occasional calls of up to 10 minutes. Calls that run longer than 10 minutes are considered partial sessions, and will be billed on a pro-rated basis, according to our hourly rate. Frequent calls between sessions may incur a partial session fee, but we will discuss this in more detail should it occur. Upon your request, and with the proper release of information, we are happy to collaborate by phone with other treatment providers, schools, parents, etc., in providing continuity of client services. Phone sessions are possible at the discretion of the therapist, but are not reimbursed by insurance companies, and therefore are your responsibility. The fees are calculated using the self pay hourly rate.

**Treatment Summaries/Reports:**

Upon your request, and with the proper release of information on file, we will provide written treatment summaries for school IEP's, courts, lawyers, health care providers, etc. Please understand that the preparation of these documents takes time, and you will be charged a fee, that is in addition to your session fee. These fees are non-reimbursable by insurance carriers, and therefore will be your responsibility. The fees are calculated using our self pay session hourly rate. Any appearances in court will be billed at twice our private pay hourly rate plus travel time.

Thank you for your understanding of our financial policies. Please let us know if you have any questions. By signing below, you are stating that you understand, agree, and abide by these terms and conditions.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## *Release of Information*

Client Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I authorize the use and disclosure of the following health information about me by Miller Counseling & Associates, Inc.. I understand that such disclosures can only be made to the person(s) or organizations identified below, and only for the time indicated. I have a right to revoke this Release of Information at any time.

**Persons or Organizations receiving the information:**

Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Specific Information to be Used or Disclosed:**

\_\_\_ Psychiatric Assessment/Diagnosis

\_\_\_ Psychological History

\_\_\_ Medications Dose/Times

\_\_\_ Course of Therapy

\_\_\_ Psychosocial Testing

Other \_\_\_\_\_

**Release of Information is effective for the following dates:**

Start \_\_\_\_\_ End \_\_\_\_\_ Open Ended \_\_\_\_\_

Client Signature \_\_\_\_\_ Parent (if applicable) \_\_\_\_\_

Date \_\_\_\_\_

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As of (date) \_\_\_\_\_, I wish to revoke this Release of Information.

Client Signature \_\_\_\_\_ Parent (if applicable) \_\_\_\_\_

## ***Credit Card Information***

All clients are ***required*** to have a valid credit card on file with Miller Counseling & Associates, Inc. The card on file can be used to cover weekly charges, such as deductibles, copayments, coinsurances and/or agreed upon rates, if you choose to pay by credit card.

A \$5.00 processing fee will be added for payment with a credit card. For HSA or Flex spending account cards, this fee must be paid by check or cash.

Failed appointments, sessions cancelled with less than 24 hours notice, and any unpaid balance on your account greater than 30 days past due, will automatically be charged to the card on file. Your credit card statement will act as your receipt.

In addition, any disputed charges that result in a charge back fee(s), as determined by the credit card processing service, will be your responsibility to pay in addition to the original disputed transaction amount.

It is your responsibility to update Miller Counseling & Associates, Inc. of any changes to your credit card information (type of card, expiration date, etc).

By signing below, you acknowledge your understanding of the above information and agree to these terms.

\_\_\_\_\_

|                           |      |
|---------------------------|------|
| Client/Guardian Signature | Date |
|---------------------------|------|

Card Type (circle) VISA    MASTERCARD    DISCOVER    MEDICAL/FLEX CARD

Cardholder's Name \_\_\_\_\_

Credit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Address \_\_\_\_\_

Card Holder's Phone # \_\_\_\_\_

Card Holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

Email Address \_\_\_\_\_

## ***Insurance Coverage Bulletin***

As a health care provider, we choose to contract with certain insurance plans/companies, in order to offer our services at a discounted rate; helping to reduce our client's health care costs. In doing so, we receive a lower payment amount, and our reimbursement is delayed. Therefore, deductibles, copayments, and any unpaid balances are due at the time of service. **We do not have anything to do with the specifics provided under your health care plan—that is an agreement between yourself and your insurance carrier.** For your convenience, we will contact your carrier for an **estimate** of coverage. Your insurance carrier has a disclaimer which states, “we will not guarantee the amount of coverage prior to your claim having been processed”. Insurance companies have been known to misquote benefits, delay uploading current benefit information, and/or change the specifics on individual plans. Additionally, insurance companies are coming out with new plans, and new plan levels all the time. We are not privy to changes in your coverage, or plan specifics, unless you inform us.

In addition to staying current with coverage specifics, it is to your advantage to be diligent with the explanation of benefits your carrier provides you with. We only have access to what your plan has/has not paid us; we do not know costs you have incurred with other providers. Therefore we have no way of knowing how much has been applied towards your annual deductible, where you are in relation to your total out of pocket costs, or to the order in which your insurance carrier processes the various providers claims.

### ***Additional trends in insurance coverage:***

- Insurance companies often outsource mental health benefits to a different insurance company from which you receive your medical coverage. Therefore, benefits for physical health and mental health may have different coverage. Your card may not reflect this.
- While your carrier provides an estimate of your annual deductible, deductible amounts can vary for medical and mental health; there may be a deductible for one, and not the other.
- Even though your plan covers mental health, it may limit types of coverage, (i.e. couples counseling), the length of time we are in session, or the frequency of sessions.
- We may be a preferred provider with your insurance company, but not be a provider for the specific plan you have with them. Each insurance carrier has various PPO's; each having different levels of coverage.
- Hospitals, clinics, and other health care providers, are increasingly contracting out some of the services they provide. For example, you may go to an in-network hospital, but the Laboratory and radiology departments are out of network providers.

**Check to be sure that each of your providers is covered under your specific plan.**

Because of the numerous insurance changes, it is more important than ever that you are an educated consumer of your health care services, and that begins with staying current with coverage under your specific plan. You are ultimately responsible for your bill, and knowing which providers and services are covered may save you costly health care bills.

***Insurance Coverage Bulletin Signature Form***

Miller Counseling & Associates, Inc. has provided me with a copy of Insurance Coverage Bulletin. I have read the document and understand its content. I understand that I am ultimately responsible for any unpaid balance on my account; including but not limited to bank fees, denied claims, failed appointments, etc. I also understand that I am responsible for staying current with my insurance benefits, and notifying my therapist of any changes prior to my next appointment. Failure to do so will result in my being charged the cash rate for each session I attend, until my benefits can be verified.

Client: \_\_\_\_\_

Date: \_\_\_\_\_