PATIENT INFORMATION:

Patient's Name: _____
D.O.B.: ___/____/_____ Age: _____ Sex: _____M_____F

Race: __W__Bl__Bi__Other Marital Staus: ___S___M___D___Sep___W Social Security #: _____-_____-_____

Street: _____
City, State, Zip: _____

Cell Phone #: (____)_____-_____ Home Phone #: (____)_____-_____ Work Phone #: (____)_____-_____

EMAIL ADDRESS: _____ May we send your invoices by email? ___yes ___no

If Patient is a Minor, List Parents:_____ D.O.B.:____/____/_____
Otherwise List Spouse (if applicable)_____ D.O.B.:____/____/_____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
School:_____ Current Grade: _____
School Adjustment: _____Excellent _____Good _____Fair _____Poor

Although it is your responsibility to remember your appointment time, our office staff tries to give reminder calls to patients about scheduled appointments when time is available to do so. Please indicate if you give permission for such calls and the best number to contact you for reminder calls.
_____Yes, please contact me at the following number(s): _____ ; _____
_____No, please do not contact me

FAMILY INFORAMATION:

Immediate Family Composition of PATIENT: AGE LEVEL OF EDUCATION

Father / Husband: _____ _____ _____
Mother / Wife: _____ _____ _____
Children: _____ _____ _____
_____ _____ _____
_____ _____ _____

Principal Family Type: ___ 2 natural parents ___1 parent/step-parent ___adoptive parents ____single parents
___ foster family ___relative ___other_____

Other Persons Living in Home: _____

Person to Contact in Case of an Emergency: _____ Relationship: _____
Address of Emergency Contact: _____ Phone Number: (____)____- _____

MEDICAL INFORMATION:

List any current Medical Problems: _____ Current Health Status: ___Excellent___Good___Average___Poor
_____
_____ Allergies: _____

Most insurance companies are requiring us to contact your physician to coordinate your medical care. Your signature will give or deny us that permission. The permission can be revoked at any time by simply making that request in writing.

I authorize contact of my physician:
_____
Date:_____/_____/_____

I do not authorize contact of my physician:
_____
Date: _____/_____/_____

Current Physician's Name: _____ Phone (____) _____-_____

(CONTINUED ON OTHER SIDE)

Physician's Address: _____
City, State, Zip: _____

Current Medications Prescribed: _____

FINANCIAL/ INSURANCE INFORMATION:

Person Responsible for Payment of Services: _____
Employer of Insured: _____ Occupation: _____

Social Security Number of Insured: _____
Spouse 's Employer: _____ Occupation: _____

Patients Relationship to PRIMARY Insured: _____Self _____Spouse _____Child _____Other_____

Is Patients Condition Related to: Employment: ____yes____no Auto Accident: ____yes____no Other Accident: ____yes____no
If 'yes' to Auto Accident, List State: _____

PRESENTING PROBLEMS: Please describe the concerns you, your child, and/or your family are experiencing.

_____

_____

_____

Please list other counseling/treatment services for yourself and/or family members with the approximate dates. _____
_____

REQUIRED AUTHORIZATION SIGNATURES

I authorize the release of any medical information necessary to process this claim with my insurance company or third party payer; and, I authorize payment of medical benefits to Dr. David E. Miller for services rendered on my behalf.

SIGNATURE: _____ **Date:** _____
(PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE)

***********Signature to be made below at 1st appointment when receiving "privacy act" brochures**********

I have received and reviewed a copy of the practice's Notice of Privacy Practices & Client Information and Policy Brochure. I agree to the terms of these documents and my signature below serves as an acknowledgment that I have received copies of the same. I voluntarily consent for myself and/or my family to be evaluated and/or seen in therapy, by Dr. David Miller or one of his associates. I further agree to be responsible for collection fees charged for services. If I default and my account is turned over to collections, I agree to also be responsible for fees of the collection agency utilized, which may be based on a percentage at a maximum of 29% of the debt, and all costs, and expenses, including reasonable attorneys' fees, incurred in such collection efforts.

SIGNATURE: _____ **Date:** _____
(PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE)

OPTIONAL AUTHORIZATION SIGNATURES

CONSENT FOR E-MAIL COMMUNICATIONS: By voluntarily agreeing to provide my e-mail address below, I am authorizing Dr. Miller to send, receive, and exchange e-mail messages from that e-mail account. I fully understand the inherent risks associated with the use of e-mail. I acknowledge that Dr. Miller ultimately cannot guarantee the privacy and confidentiality of any of my Protected Health Information that may be shared or exchanged via e-mail. I assume full responsibility for any adverse outcomes that may arise as a result of my decision to communicate with Dr. Miller via e-mail. I understand that the use of e-mail is a voluntary option and I have the right to decline or revoke this option at any time by so indicating my withdrawal of authorization in a written request.

E-mail Address: _____
(please leave blank if you DO NOT agree with consent described above)

SIGNATURE: _____ **Date:** _____
(PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE)