Richard H Miller, LCSW

21620 Hwy 10
Little Rock, AR 72223
(501) 580 - 2308
http://www.richardhmiller.org/

********** Client Information **********

Last Name	First Name	Middle Initial	Date of Birth	Social Security Number

Street Address	City	State	Zip Code

Home Phone	Cell Phone	Email

Employment	Education (grades completed)	Marital Status (List previous marriages on back)	Members of Household (list ages)

Spouse's Name	Spouse Date of Birth	Spouse's Education	Spouse's Employment

Previous Physical Problems	Primary Physician	Previous Psychotherapy

Recent Drug/Alcohol Use / Past History of Drug Alcohol Problems

Psychiatric Medications

Who Referred you (Self, Physician, Other)

What Needs/Expectations for Therapy (Be Specific)

********** Insurance Information **********

☐ Yes ☐ No Copy of Insurance card attached

Name of *Primary* Insurance — Member ID

Subscriber Name (Name of Insured) — Relationship to Client

☐ Yes ☐ No Copy of Insurance card

Name of *Secondary* Insurance — Member ID

Subscriber Name (Name of Insured) — Relationship to Client

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

This document will inform you about what you can expect regarding confidentiality and other details regarding your treatment.

CONFIDENTIALITY & RECORDS

Your therapy sessions and any communications with me will become part of your clinical record of treatment which is referred as Protected Health Information (PHI). Your PHI record will be kept safe within my office and will be completely confidential, with the following exceptions: (1) you sign a "Release of Information" form directing me to send your record to another care provider; (2) you have made a verbal or physical threat towards me; (3) I determine that you are a danger to yourself or to others; (4) you report information about the abuse of a child, elderly person, or a disabled individual who may require protection; (5) I receive court orders to disclose information.

STATEMENT REGARDING ETHICS, CLIENT WELFARE & SAFETY

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the National Association of Social Workers. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please notify me immediately. Due to the nature of psychotherapy, I am unable to guarantee specific results regarding your psychotherapy. However, with your participation, we will develop agreed upon goals so we can evaluate the treatment plan developed for you to ensure accountability and the best possible results for you.

HIPPA NOTICE

I hereby acknowledge that I have been presented with a copy and have read the notice of HIPAA regulations. I also waive my right to privacy and will allow the disclosure of my health information to the appropriate individuals/institutions. Initial _____

CANCELLATION POLICY

Dr. Miller's method of conducting individual or couples/family psychotherapy is the brief, goal-oriented approach. In order for you to accomplish your goals, appointments are scheduled on a weekly basis, unless you and Dr. Miller agree that more frequent sessions are needed. Therefore, it is important to keep all scheduled appointments. If it is necessary to cancel an appointment, you need to reschedule within that week. If you call to cancel **two (2)** days before the next scheduled appointment, then Dr. Miller has time to schedule another client in your slot. This allows Dr. Miller to fill that slot with another client for only that one session, while keeping your time slot reserved for the following and subsequent weeks. There is no charge when this is done two days prior to the scheduled appointment. If you call ***less than*** two (2) days before the scheduled appointment, then Dr. Miller will discuss with you at that time the charge for the missed appointment and will reschedule another appointment for the following week. Missed appointment where Dr. Miller was not contacted ("no shows") will be charged the full rate. Dr. Miller will seek to return all calls to reschedule; however, it is your responsibility to make contact to reschedule. The purpose of this policy is to maximize the benefits of psychotherapy to help you make the desired changes in your life.

I have read and understand this policy: _____ Date: _____

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rwholehealth@aristotle.net

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION FORM

Patient Name	Date of Birth
Home Phone	Cell Phone

Street Address	City	State	Zip Code

Please Note: Copy Fee May Be Charged For Medical Records

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Richard H Miller, LCSW services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Miller to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested services from Richard H Miller, LCSW on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

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Patient/Responsible Party Signature

Date