L. Miller
COUNSELING, LLC

Client Information

Name: _____

Home Address:_____

City:_____State:_____Zip:_____

E-mail address: _____Birthdate:_____

Client's Cell Phone: _____

I authorize Linda Miller, LMFT to leave appointment reminders or changes on the telephone number or e-mail address listed above. I understand that I have the right to revoke this consent at any time in writing, and that revocation will only apply to future uses of this information.

Voicemail messages	Yes_____	No_____
Text messages	Yes_____	No_____
E-mail messages	Yes_____	No_____

Other phone (work/home): _____

Referred by: _____

THIS SECTION IS TO BE COMPLETED ONLY IF CLIENT IS UNDER 18 YEARS OLD

Parent(s) Name/Cell Phone/Email: _____

_____

Address: _____

City:_____State:_____Zip:_____

If client is under 18, and parents are divorced, are both biological parents aware that the child is attending therapy at L. Miller Counseling, LLC? Yes_____ No_____
If you checked "No," you agree you will communicate to the child's other biological parent that the child has begun attending therapy sessions with Linda Miller, LMFT after the first session. Initial here: _____

I give Linda Miller, LMFT consent to provide counseling services to my child.

_____ _____
Signature of Parent/Guardian/Legal Representative Date

END OF CHILD ONLY SECTION

Occupation/School: _____

Marital Status: _____ Significant Other: _____

Family Physician: _____Phone: _____

Address: _____

Allergies and Other Health Concerns: _____

_____

Physical Health Medications: _____

_____

Current Psychiatric Medications: _____

_____

_____

Psychiatric Medication Prescriber: _____

Address: _____

Phone: _____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

Insurance Information

Primary Company: _____

Policy Subscriber's Name: _____

Subscriber's Policy Number: _____Group Number: _____

Subscriber's Date of Birth:_____

Subscriber's Address: _____

Subscriber's Phone Number: _____

Co-Payment/Co-Insurance: _____ Deductible: _____

Secondary Company: _____

Policy Subscriber's Name: _____

Subscriber's Policy Number: _____Group Number: _____

Subscriber's Date of Birth:_____

Subscriber's Address: _____

Subscriber's Phone Number: _____

Co-Payment/Co-Insurance: _____ Deductible: _____

Financial Policy

Please initial the blank next to each paragraph indicating that you have read and understand the policy regarding payment for services.

_____**INSURANCE COVERAGE** It is your responsibility to verify current coverage with your insurance provider. Any changes to your insurance policy or coverage must be reported to L. Miller Counseling, LLC before services are rendered. L. Miller Counseling, LLC will bill your insurance company for all services provided to you, however, if for any reason your insurance company does not pay, you are responsible for paying the out-of-pocket expense for the service you received. It is your responsibility to know which services are covered by your insurance company. Please be advised that some or all of the services provided may be "non-covered" services and may not be considered reasonable and necessary under the Medicaid program and/or your medical insurance. You are responsible to pay your co-payment and deductible (if applicable). **Your co-pay is due at each session. If you have no insurance, or you have not met your deductible, the full fee is due at each session.**

L. Miller COUNSELING, LLC

_____**CHARGES FOR MINOR CHILDREN** If the person responsible for the balance of the account is not present, the parent, legal guardian, or person present will be assumed to be the responsible party, regardless of court orders or any other documentation placing responsibility of payment fees upon one parent or the other.

_____**CHARGES FOR CANCELLATIONS OR MISSED APPOINTMENTS** There will be no charge if you call and cancel your appointment at least 24 hours prior to your appointment. Please be aware your appointment time has been reserved exclusively for you. **You will be charged $25 for less than 24 hours advanced notice, and $50 for same day cancellation/missed appointment.** Please note that insurance companies will not reimburse you for missed/cancelled sessions. Two missed appointments constitute grounds for termination of counseling services.

_____**CREDIT CARD ON FILE** A credit card is required on file for each visit. This will improve office efficiency for any unpaid balance, including but not limited to missed/cancelled appointments and/or co-pays, coinsurance, or cost not covered by your insurance company. Your credit card information is kept confidential and secure, and payments to your card are processed only after your scheduled session time is completed or after a missed/cancelled appointment.

By signing below, I am authorizing L. Miller Counseling, LLC to charge the card provided on file for services rendered or as stated above in the financial policy. I may still pay by cash, check, health savings account, or a different card at the time of my appointment per my request. By signing below, I acknowledge that all bills may be sent to me directly (or the person listed on the payment information form) and payment of all charges not covered by insurance will be solely my responsibility.

_____ _____

Signature of Client/ Legal Representative Date

_____

Relationship to Client

_____ _____

Witness Date

Notice of Privacy Practices, HIPAA Statement

In compliance with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, this notice describes how information about you may be used and disclosed, and how you may obtain access to this information. Please review it carefully.

Our commitment to your privacy:

1. L. Miller Counseling, LLC is dedicated to maintaining the privacy of your personal information (i.e. health, education, etc.) as part of providing professional care. We are required by law to keep your information private. We will use the information that is obtained from you or from others in relation to you to provide you with necessary services, to arrange payment, and/or for other business activities which are called, in the law, health care operations. Psychotherapy/therapy notes will not be disclosed to others.

2. It is L. Miller Counseling, LLC's goal to always keep your information private, but there are times when the law requires us to use or share it. This may be done without your authorization. For example:
    - When there is a serious threat to your health and safety, or the health and safety of another individual, or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
    - If required by a lawsuit, legal or court proceedings, or worker's compensation, and similar benefit programs.
    - If a law enforcement official or the law (as in mandatory reporting) requires us to do so.

3. If you or L. Miller Counseling, LLC wants to use or disclose (send, share, release) your information for any other purpose, we will discuss this with you and ask you to sign a "Release of Information" form prior to obtaining, disclosing or releasing information. If the client is a minor, this may require a parent or legal guardian's authorization. You have the right to receive a list of disclosures made by your therapist.

Your rights regarding your personal information:

1. L. Miller Counseling, LLC may contact you at the phone numbers, mailing and e-mail addresses that you give us about treatment and services. You may ask us to communicate with you about your health and related issues in a particular way, or at a certain place which is considered more private by you.

2. You have the right to ask us to limit what is shared with people involved in your care, such as family members and friends.

3. You have the right to review your file upon request with your counselor, however, some records are protected by law and are not available. Some documents may not be reviewed if psychologically harmful to you.

4. If you believe the information in your records is incorrect, or important information is missing, you may ask us to make changes (called amendments) to your records. You must make this request in writing and explain the reason for the changes.

5. You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this notice or our privacy policies, please contact your therapist, Linda Miller, LMFT at 515-421-4224.

I ,_____, acknowledge that I have received a copy of L. Miller Counseling, LLC's Notice of Privacy Practices, HIPAA Statement which summarizes the ways my identifiable health information may be used and disclosed by this provider and states my rights with respect to my medical information. I understand this provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event this provider revises the information regarding privacy practices, a revised notice will be available at 1200 Valley West Drive, Suite 408, West Des Moines, IA 50266 and that I may obtain a current Notice of Privacy Practices at any time.

_____ _____

Signature of Client/ Legal Representative Date

_____

Relationship to Client

_____ _____

Witness Date

L. Miller COUNSELING, LLC

Permission to Treat/Client Rights and Responsibilities

Consent to the Use and Disclosure of Health Information for the Purposes of Treatment, Payment or Health Care Operations:

I understand that as a part of my care, Provider will originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment, including consulting with my referring physician, and staff of any healthcare facility that I am transferred to for continuance of care in an emergency
- A source of information for applying my diagnosis and procedure information to my bill
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as quality assurance

Notice of Privacy Practices:

I have reviewed the Provider's Notice of Privacy Practices prior to signing this consent. The Provider's Notice of Privacy Practices summarizes the way my medical record may be used or disclosed by the Provider and states my rights with respect to my medical information. I understand that Provider has the right to revise its information practices and to amend the Notice. I understand that in the event Provider revises its Notice of Privacy Practices, a revised Notice will be posted in the office, and I may obtain a current Notice at any time from the provider.

Right to Restrict Disclosure:

I understand that I have the right to restrict how the Provider uses and discloses all or any part of my medical record for treatment, payment, or health care operations. I further understand that the provider does not have to agree to such restrictions.

Right to Revoke at Any Time:

I understand that I have the right to revoke this consent at any time in writing. I understand that any revocation by me of this consent will only apply to future uses and disclosures and such revocation must be in writing.

Authorization for Services:

I give permission to Provider to perform diagnostic and/or treatment services. I authorize payment directly to Provider from my insurance company. I also accept responsibility for payment of services I request or which are required for my treatment which may not be covered by my insurance. I am responsible for contacting my insurance company for initial authorization and verifying my mental health benefits. I am responsible for all fees applied to my account for treatment and services.

Payment at Time of Service:

I understand Provider's policies regarding payment for services, and will make payment in full at the time of each visit unless other arrangements have been made in advance. Insurance will be filed by the office at no charge, and I will make all deductible, co-payments, or non-covered service payments at the time of service.

Cancelled or Missed Appointments: I understand that when scheduling an appointment, I am reserving professional time in advance. It is my responsibility to keep scheduled appointments. If unable to keep an appointment, I agree to provide a minimum of 24-hour notice. I acknowledge that a pattern of missed appointments constitutes grounds for termination of services.

Court-Related Work:
If Provider is called upon to appear in court, testify in court, or prepare reports for the court related to service I received, I agree to pay for all such services. A list of fees associated with court services is available upon request.

After Hours Care:
I understand that Provider will respond to phone calls, texts and emails during normal business hours, but will not be available to me outside of those hours. I understand that the Provider's email address and text messages are available only for scheduling appointments, and are not intended for clinical services and are not continually monitored or encrypted for security.

Social Media Contact:
I understand that my relationship with the Provider is that of a professional nature. The Provider is not permitted to accept friend or contact requests on social media sites from clients as this could compromise confidentiality and respective privacy.

Credit Card on File:
I authorize Provider to charge my credit card for services rendered, no shows and cancellations made less than 24 hours and is to be used for future transactions from my account. I understand that I may cancel this authorization at any time by contacting Provider, and that this authorization will remain in effect until cancelled. I understand that I can change credit cards I have on file at any time.

_____ _____
Signature of Client/ Legal Representative Date

_____
Relationship to Client

_____ _____
Witness Date