



PATIENT INFORMATION

(Please Use Dark Ink & Print Clearly)

MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
NAME: FIRST M.I. LAST SSN: (PARENT/GUARDIAN #, IF UNDER 18)
BIRTHDATE: / / MALE FEMALE HOME PHONE: MOBILE PHONE:
ADDRESS: CITY: STATE: ZIP CODE:
EMAIL ADDRESS: DRIVERS LIC.#:
PATIENT'S EMPLOYER (PARENTS, IF MINOR): WORK PHONE:
WORK ADDRESS: CITY: STATE: ZIP CODE:
SCHOOL/COLLEGE, IF PATIENT IS A STUDENT: CITY: STATE:
NAME OF SPOUSE (IF APPLICABLE): SPOUSES EMPLOYER'S PHONE:
CONTACT IN CASE OF AN EMERGENCY?: PHONE:
HOW WERE YOU REFERRED TO OUR OFFICE?: (IF FROM INTERNET PLEASE INDICATE WEBSITE)

RESPONSIBLE PARTY (Complete only if different from Patient)

PERSON RESPONSIBLE FOR ACCOUNT: RELATIONSHIP TO PATIENT:
ADDRESS: CITY: STATE: ZIP CODE:
SSN: BIRTHDATE: / / HOME PHONE: DRIVERS LIC.#:
EMPLOYER: WORK PHONE:
WORK ADDRESS: CITY: STATE: ZIP CODE:

INSURANCE INFORMATION - PRIMARY

NAME OF INSURED: RELATIONSHIP TO PATIENT:
SSN: BIRTHDATE: / / HOME PHONE: WORK PHONE:
ADDRESS: CITY: STATE: ZIP CODE:
EMPLOYER: ADDRESS: DATE EMPLOYED: / / MONTH YR
INSURANCE COMPANY: INS. PHONE #:
INS. CO. ADDRESS: CITY: STATE: ZIP CODE:
INSURED'S ID#: INSURED'S GROUP #:
HOW MUCH IS YOUR DEDUCTIBLE?: AMOUNT USED: MAXIMUM ANNUAL BENEFIT:
CO-PAYMENT AMOUNT: CO-INSURANCE %: IS PREAUTHORIZATION REQUIRED?: YES NO

INSURANCE INFORMATION - SECONDARY (If Applicable)

NAME OF INSURED: RELATIONSHIP TO PATIENT:
SSN: BIRTHDATE: / / HOME PHONE: WORK PHONE:
ADDRESS: CITY: STATE: ZIP CODE:
EMPLOYER: ADDRESS: DATE EMPLOYED: / / MONTH YR
INSURANCE COMPANY: INS. PHONE #:
INS. CO. ADDRESS: CITY: STATE: ZIP CODE:
INSURED'S ID#: INSURED'S GROUP #:
HOW MUCH IS YOUR DEDUCTIBLE?: AMOUNT USED: MAXIMUM ANNUAL BENEFIT:
CO-PAYMENT AMOUNT: CO-INSURANCE %: IS PREAUTHORIZATION REQUIRED?: YES NO

PLEASE PROVIDE YOUR COORDINATE

## BILLING POLICIES/LATE CHARGES

- 1) BY SIGNING THIS, YOU ARE CONSENTING TO TREATMENT PROVIDED BY Dr. Amy D. Miller (PROVIDER). YOU MAY TERMINATE TREATMENT AT ANY TIME WITHOUT PENALTY. ANY CONCERNS REGARDING TREATMENT SHOULD BE DISCUSSED WITH THE PROVIDER.
- 2) **FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION OF A SCHEDULED APPOINTMENT IS REQUIRED.** IF CANCELLATION IS MADE AFTER THIS TIME IT WILL BE CONSIDERED A "FAILED APPOINTMENT" AND YOU WILL BE CHARGED FOR THE FULL SESSION TIME RESERVED FOR YOU. IN THE CASE OF AN EMERGENCY, DEATH IN THE FAMILY, HOSPITALIZATION, ILLNESS, ETC., PLEASE SPEAK WITH YOUR PROVIDER REGARDING PAYMENT. IT IS UNDERSTOOD THAT TIME HAS BEEN RESERVED FOR YOU AND THE LACK OF ADEQUATE NOTICE PREVENTS SUFFICIENT TIME TO SCHEDULE OTHER PATIENTS WHO MAY BE IN NEED. IT IS ALSO UNDERSTOOD THAT **YOUR INSURANCE COMPANY WILL NOT PAY FOR A FAILED APPOINTMENT AND THAT YOU WILL BE RESPONSIBLE FOR THE FULL FEE.**
- 3) THE UNDERSIGNED AGREES THAT IN CONSIDERATION OF THE SERVICES TO BE RENDERED TO THE PATIENT HE/SHE AGREES TO PAY THE PROVIDER IN ACCORDANCE WITH THE TERMS OUTLINED AND AT THE PROVIDER'S CURRENT RATES. CHANGES TO RATES WILL OCCUR FROM TIME TO TIME AND WILL BE POSTED PRIOR TO THE EFFECTIVE DATE OF THE RATE CHANGE.
- 4) PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF USING INSURANCE BENEFITS, IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO DETERMINE YOUR PORTION DUE. YOUR BALANCE DUE IS YOUR FULL RESPONSIBILITY. YOUR PROVIDER REMITS CLAIMS AND ACCEPTS PAYMENTS FROM INSURANCE COMPANIES AS A COURTESY ONLY (FOR ALL NON-CONTRACTED CARRIERS).
- 5) SHOULD THE ACCOUNT BE REFERRED TO AN AGENCY OR ATTORNEY FOR COLLECTION, THE UNDERSIGNED WILL PAY ALL REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSE. THE UNDERSIGNED SHALL ALSO BE RESPONSIBLE FOR ALL INTEREST, AFTER 60 DAYS, OF THE LESSER OF 1.5% MONTHLY (18.0% ANNUAL), OR THE MAXIMUM INTEREST RATE ALLOWED BY LAW, OF THE UNPAID MONTHLY BALANCE.
- 6) IF FAILURE TO COMPLY WITH THESE OBLIGATIONS, EACH CONSENTS TO THE DISCLOSURE OF THEIR IDENTITY AND OTHER NECESSARY INFORMATION RELATING TO SERVICES RENDERED TO THE PATIENT, BY THE PROVIDER, TO ANY THIRD PARTIES, INCLUDING COLLECTION AGENCIES AND/OR LEGAL REPRESENTATIVES FOR THE PURPOSE OF ENFORCING THE PATIENT'S OR GUARANTOR'S OBLIGATIONS TO THE PROVIDER. SUCH DISCLOSURE OR REDISCLOSURE SHALL NOT BE DEEMED TO BE A BREACH OF THE PATIENT'S CONFIDENTIALITY BY THE PROVIDER.
- 7) BY PROVIDING YOUR EMAIL ADDRESS YOU AUTHORIZE YOUR PROVIDER & BILLING PERSONNEL TO SEND & RECEIVE EMAILS TO/FROM YOU. IF YOU DO **NOT** WANT ANY CORRESPONDENCE BY EMAIL PLEASE CHECK HERE.

### SIGNATURE

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND AGREE TO THESE CONDITIONS.

X

DATE:        /        /

\_\_\_\_\_  
SIGNATURE OF PATIENT, OR GUARDIAN IF MINOR

### AUTHORIZATION AND RELEASE

I AUTHORIZE Dr. Amy D. Miller (PROVIDER), IT'S AGENTS OR ASSIGNS, TO RELEASE ANY INFORMATION OF THE PATIENT, INCLUDING DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED, DURING THE PERIOD OF SUCH CARE, TO THE PROVIDER'S EMPLOYEES OR CONTRACTORS, THIRD PARTY BILLING AGENTS, THIRD PARTY PAYOR'S, OR OTHER SUCH PARTIES NECESSARY FOR THE PURPOSE OF CLAIMS PROCESSING AND OBTAINING PAYMENT FOR SERVICES RENDERED TO THE PATIENT.

I AUTHORIZE AND REQUEST THAT MY INSURANCE COMPANY PAY DIRECTLY TO Dr. Amy D. Miller (PROVIDER) INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER ACKNOWLEDGE AND AGREE THAT MY SIGNATURE AUTHORIZES THE PROVIDER, OR THE PROVIDER'S EMPLOYEES OR AGENTS, TO SUBMIT CLAIMS AND OTHER REQUESTS FOR PAYMENT ON MY BEHALF OR MY DEPENDENTS.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X

DATE:        /        /

\_\_\_\_\_  
SIGNATURE OF PATIENT, OR GUARDIAN IF MINOR



# DR. AMY D. MILLER & ASSOCIATES, LTD.

Welcome to our office; Please complete the following:

Date \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ (Required)

Height \_\_\_\_\_ ft \_\_\_\_\_ Inches Weight \_\_\_\_\_ lbs Date of Birth \_\_\_\_\_

Marital Status (check one)  Single  Engaged  Married (how long? \_\_\_\_\_)  Separated  Divorced  
 Widowed  Remarried (how many times? \_\_\_\_\_)  Living with someone

### Children / Step Children

Name	Age	Relationship	Living at Home Y/N

### Siblings

Gender (M/F)	Age

Parents Living? Y / N Adopted? Y / N

Name of family physician (N/A if none) \_\_\_\_\_ Phone# \_\_\_\_\_

Name of psychiatrist (N/A if none) \_\_\_\_\_ Phone# \_\_\_\_\_

### DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your problem(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please estimate the severity of your problems on the the following scale:

Mildly upsetting  Moderately upsetting  Very severe  Extremely severe  Totally incapacitating

When did the problem(s) begin (give dates) \_\_\_\_\_  
\_\_\_\_\_

Please describe significant event(s) occurring at that time, or since then, which may relate to the development or maintenance of the problem(s) \_\_\_\_\_  
\_\_\_\_\_

What solution to your problem(s) have been most helpful? \_\_\_\_\_  
\_\_\_\_\_

Have you been in psychotherapy before or received any prior professional assistance for the problem(s)? If so, please give name(s), professional title(s), dates of treatment and results \_\_\_\_\_  
\_\_\_\_\_

Your expectations regarding psychotherapy \_\_\_\_\_

In general, what do you think psychotherapy is all about? \_\_\_\_\_

How long do you think your therapy should last? \_\_\_\_\_

**Check any of the following behaviors that apply to you:**

- |                                   |  |   |  |   |
|-----------------------------------|--|---|--|---|
| <input type="checkbox"/> Overeat  | <input type="checkbox"/> Impulsive reactions | <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Take too many risks | <input type="checkbox"/> Nervous tics     |
| <input type="checkbox"/> Smoke    | <input type="checkbox"/> Sleep disturbance   | <input type="checkbox"/> Aggressive behavior        | <input type="checkbox"/> Eating problems     | <input type="checkbox"/> Take Drugs       |
| <input type="checkbox"/> Crying   | <input type="checkbox"/> Outbursts of temper | <input type="checkbox"/> Odd behavior               | <input type="checkbox"/> Work too hard       | <input type="checkbox"/> Loss of control  |
| <input type="checkbox"/> Lazy     | <input type="checkbox"/> Drink too much      | <input type="checkbox"/> Compulsions                | <input type="checkbox"/> Suicide attempts    | <input type="checkbox"/> Can't keep a job |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Withdrawal          | <input type="checkbox"/> Phobic avoidance           | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Panic attacks    |
|                                   |  |   | <input type="checkbox"/> Sexual Problems     | <input type="checkbox"/> Procrastination  |

Are there any specific behaviors, actions, or habits that you would like to change? \_\_\_\_\_

What are some specific talents or skills that you feel proud of? \_\_\_\_\_

What would you like to do more of? \_\_\_\_\_

What would you like to do less of? \_\_\_\_\_

What would you like to start doing? \_\_\_\_\_

What would you like to stop doing? \_\_\_\_\_

How is your free time spent? \_\_\_\_\_

Do you keep yourself compulsively busy doing an endless list of chores or meaningless activities? \_\_\_\_\_

Do you practice relaxation or meditation exercises regularly? \_\_\_\_\_

**PHYSICAL SENSATIONS**

Check any of the following that often apply to you

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Tingling        | <input type="checkbox"/> Fainting spells       | <input type="checkbox"/> Rapid heart beat         |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Numbness        | <input type="checkbox"/> Hear things           | <input type="checkbox"/> Don't like to be touched |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Flashes               | <input type="checkbox"/> Blackouts                |
| <input type="checkbox"/> Muscle Spasms       | <input type="checkbox"/> Tics            | <input type="checkbox"/> Watery eyes           | <input type="checkbox"/> Excessive sweating       |
| <input type="checkbox"/> Tension             | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Skin problems         | <input type="checkbox"/> Visual disturbances      |
| <input type="checkbox"/> Sexual disturbances | <input type="checkbox"/> Twitches        | <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Hearing problems         |
| <input type="checkbox"/> Unable to relax     | <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Burning or itchy skin |   |
| <input type="checkbox"/> Bowel disturbances  | <input type="checkbox"/> Tremors         | <input type="checkbox"/> Chest Pain            |   |

What sensations are especially:

Pleasant for you? \_\_\_\_\_

Unpleasant for you? \_\_\_\_\_

**BIOLOGICAL FACTORS**

Do you have any current concerns about your physical health? Please specify \_\_\_\_\_

Please list any medicine(s) you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicine(s) that were prescribed or taken over the counter) \_\_\_\_\_

Check any of the following that apply to you or members of your family

Mental Health History

<u>Family</u>	<u>Self</u>		<u>Family</u>	<u>Self</u>		<u>Family</u>	<u>Self</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	ADHD/Learning disability
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar
<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	OCD
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/ Drug Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Have you ever had any head injuries or loss of consciousness? Please give details \_\_\_\_\_

Please describe any surgery you have had (give dates) \_\_\_\_\_

Please describe any accidents or injuries you have suffered (give dates) \_\_\_\_\_

Do you eat three well-balanced meals each day? If not, please explain \_\_\_\_\_

Do you get regular physical exercise? If so, what type and how often? \_\_\_\_\_

Check any of the following that apply to you:

	<u>Never</u>	<u>Rarely</u>	<u>Frequently</u>	<u>Very Often</u>		<u>Never</u>	<u>Rarely</u>	<u>Frequently</u>	<u>Very Often</u>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aches/Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painkillers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Backach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Early morning awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fitful sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants/Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat "junk foods"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					



# Dr. Amy D. Miller & Associates, Ltd.

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## Patient Instructions:

Please complete by signing, dating and providing information in the sections below. Retain both the **NOTICE OF PRIVACY POLICY & NOTICE OF CLIENT EMAIL/TEXTING INFORMED CONSENT** for your records. **RETURN ONLY THIS PAGE TO OUR OFFICE.**

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### Patient's Acknowledgement of NOTICE OF PRIVACY POLICY

I hereby acknowledge that I have been provided with the practice's **NOTICE OF PRIVACY POLICY** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name	Signature of Patient/Responsible Party	Date
<i>Privacy Notice Effective Date: <b>September 23, 2013</b> (See Privacy Notice)</i>		

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### Patient's Acknowledgement and CLIENT EMAIL/TEXTING INFORMED CONSENT agreement

I hereby acknowledge that I have been provided with the practice's **NOTICE OF CLIENT EMAIL/TEXTING INFORMED CONSENT** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction. I understand the risks associated with communication using email and/or texts between my Provider and/or my Provider's staff or agents, and me, and consent to the conditions as outlined, as well as any other instructions that may be imposed to communicate with me by email or text.

Patient Name	Signature of Patient/Responsible Party	Date
Email Address(es)	Mobile No. 1	Mobile No. 2 (if applicable)

*Client/responsible party is responsible for updating their information on this form for any changes.*

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**\*\* Only check the box(es) below if you do NOT want email, text and/or voicemail communication \*\*\***

- I do **NOT** consent to the use of email or text message communications.
- I do **NOT** consent to receiving voicemail messages.



1305 Remington Road, Suite T  
Schaumburg, IL 60173  
Phone: (847) 845-4045  
Fax: (847) 519-9089  
DrAmy@DrAmyMiller.com  
www.DrAmyMiller.com

## Dr. Amy D. Miller & Associates, Ltd.

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Office Copy

### Thank you for being our patient

In order to give you a better understanding of our services & procedures, we would like to provide you with the following information.

- Dr. Miller uses an outside billing service. If, however, you should have any questions regarding your statement, please contact Dr. Miller. If she is unable to assist you, she will contact the billing service directly. You may also contact a billing representative directly via email at **Billing@DrAmyMiller.com**. All emails sent to this address will be automatically forwarded to the billing company.
- Our office accepts payments from insurance companies as a courtesy to our patients. Please note that you are fully responsible for all charges and **it is your responsibility to contact your insurance company to verify benefits, eligibility & coverage**. Some insurance companies require preauthorization for behavioral health benefits prior to receiving any treatment. **Please check with your insurance company prior to your initial appointment and obtain an authorization if necessary**. Failure could result in a loss of insurance benefits.
- If you should change insurance carriers or have any other changes to your insurance, it is important that your clinician is notified of this change promptly & that your new insurance information is provided. Also, a copy (front & back) of your new or revised insurance card should be provided to our office promptly.
- We try to be understanding of our patient's busy schedules and lifestyles. Please note, however, that **your clinician must receive (48) hours notice of cancellation or appointment change**. Please understand that this time has been reserved for you. The lack of adequate notice prevents sufficient time to schedule other patients in need. Notice within (48) hours will be considered a "Failed" appointment. **Failed appointments are not eligible for insurance benefits and you will be responsible for payment in full**. Please discuss emergency situations with your clinician directly.
- Your appointment time slot has been reserved for you. If you arrive to your appointment late, please understand that your full session time generally cannot be provided. Abiding to the set schedule as arranged prevents disturbance to following appointments.
- Co-payments are due at the time of service. It is your responsibility to contact your insurance company to determine your portion due. Any amount due at the time of service is expected to be paid. Self payers (patients without insurance or not utilizing insurance) are responsible for paying their full session fee at the time of service.

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

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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Phone: (847) 845-4045  
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## Dr. Amy D. Miller & Associates, Ltd.

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