DR. AMY D. MILLER & ASSOCIATES, LTD.

OFFICE USE ONLY	
DIAG. CODE	

PATIENT INFORMATION *(Please TYPE for best quality - otherwise please Use Dark Ink & PRINT CLEARLY)*

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

NAME: _____ SSN: _____ (PARENT/GUARDIAN #, IF UNDER 18)
FIRST M.I. LAST *(REQUIRED)*

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 INSURANCE CARD

BILLING POLICIES/LATE CHARGES

1) BY SIGNING THIS, YOU ARE CONSENTING TO TREATMENT PROVIDED BY ***Dr. Amy D. Miller*** (*PROVDER*). 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:

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

- ☐ Headaches
- ☐ Tingling
- ☐ Fainting spells
- ☐ Rapid heart beat
- ☐ Dizziness
- ☐ Numbness
- ☐ Hear things
- ☐ Don't like to be touched
- ☐ Palpitations
- ☐ Stomach trouble
- ☐ Flushes
- ☐ Blackouts
- ☐ Muscle Spasms
- ☐ Tics
- ☐ Watery eyes
- ☐ Excessive sweating
- ☐ Tension
- ☐ Fatigue
- ☐ Skin problems
- ☐ Visual disturbances
- ☐ Sexual disturbances
- ☐ Twitches
- ☐ Dry mouth
- ☐ Hearing problems
- ☐ Unable to relax
- ☐ Back Pain
- ☐ Burning or itchy skin
- ☐ Bowel disturbances
- ☐ Tremors
- ☐ 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

Family	Self		Family	Self		Family	Self	Mental Health History
☐	☐	Thyroid disease	☐	☐	Prostate problems	☐	☐	ADHD/Learning disabilty
☐	☐	Kidney disease	☐	☐	High Blood Pressure	☐	☐	Depression
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Bipolar
☐	☐	Neurological disease	☐	☐	Heart disease	☐	☐	Anxiety
☐	☐	Infectious disease	☐	☐	Glaucoma	☐	☐	OCD
☐	☐	Diabetes	☐	☐	Infertility	☐	☐	Schizophrenia
☐	☐	Cancer	☐	☐	Arthritis	☐	☐	Alcohol/ Drug Addiction
☐	☐	Gastrointestinal disease	☐	☐	Allergies	☐	☐	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:

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

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.

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.**

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 _____

Privacy Notice Effective Date: ***September 23, 2013*** *(See Privacy Notice)*

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.

** 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.

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DrAmy@DrAmyMiller.com
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Dr. Amy D. Miller & Associates, Ltd.

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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CREDIT CARD ON FILE (CCOF) POLICY

To Our Patients:

As you are aware, healthcare has undergone dramatic changes in recent years. Insurance reimbursements are declining with high-deductible health plans and increased patient cost sharing becoming a mainstay in the healthcare landscape. This means that more responsibility for payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner to reduce increasing administrative costs. As of July 1, 2025, Dr. Amy D. Miller & Associates, Ltd. has adopted a Credit Card on File (CCOF) Policy requiring that you provide a credit card on file with our office.

This policy is being implemented to cut down on the administrative costs associated with billing. Unnecessary costs of having to bill patients multiple times or even send to a collections agency results in wasted time and expense. This change will lower administrative expenses, which is essential for us to continue to accept insurance. Some providers have decided to stop accepting insurance altogether and only accept self-pay. Other providers have also begun passing on a 3% credit card processing charge which is charged by the credit card company. Dr. Amy D. Miller & Associates, Ltd. Is implementing the Credit Card on File (CCOF) Policy to reduce administrative costs to allow continuing to accepting insurance and avoid charging the 3% credit card processing charge to patients.

Your Credit Card on File will only be used as a "backup" payment source. Please continue to pay your account when due. This will avoid administrative time and expense with having to charge your Credit Card on File. Statements are issued on the last day of each month indicating the patient's portion due (labeled "YOUR AMOUNT DUE NOW" on the last page). If your balance is not paid by 27th day of the following month, your Credit Card on File will be used to pay your balance due. (Ex./ statement is issued and sent out on March 31st, patient portion must be paid by April 27th to avoid Credit Card on File being charged.)

Your Credit Card on File is safeguarded. We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. Your credit card information is stored in a secure protected manner and only accessed and charged if there is an outstanding balance due.

A Credit Card Authorization form is attached. Please return this form by July 1st , 2025 to avoid any delays or disruption in your treatment. A fillable PDF Credit Card Authorization form can also be found on your providers website: https://dramymiller.com/patient-forms

If you have any questions, please email billing@DrAmyMiller.com

Thank you

Dr. Amy D. Miller & Associates, Ltd.

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Credit Card Information							
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____							
Credit Card #:		Expiration Date (MM/YY):		Security Code (3 or 4 digits):			
Cardholder Name (as shown on card):				Phone #:			
Cardholder Zip Code:		Email Address:					

CREDIT CARD AUTHORIZATION AGREEMENT

If there is a balance remaining on your account that is not payable by insurance benefits, you are then responsible for this balance. In Addition, in case of late cancellations and/or no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $25 will be assessed for returned checks.

I, _____ authorize Dr. Amy D. Miller & Associates, Ltd., to use my credit card information to charge if I carry an account balance not covered by insurance or in the event that I do not provide notification of my inability to attend scheduled therapy appointments and/or do not cancel my appointments at least 48 hours in advance, or if a check is returned for any reason, as agreed to in the signed Client Billing Policies/Late Charges form.

I will not dispute charges (“charge back”) for sessions I have received or for appointment I have missed according to the Client Billing Policies/Late Charges form.

By signing below I am authorizing Dr. Amy D. Miller & Associates, Ltd to charge for missed appointments and/or outstanding account balances.

I agree to promptly provide an updated credit card due to expiration or replacement.

Signature:		Date:	