Patient/Client Agreement Letter

Emmett Miller, MD

Welcome! You have scheduled an appointment with Emmett Miller MD.

Please review the following important information, as it describes the parameters of your contract with Dr. Miller. Kindly place a check in the box to the left of each heading to indicate you understand the information in that section.

Please return the signed and dated form to Dr. Miller's office email them to Drmiller@DrMiller.com, Fax: 530-470-0160 or mail them to: PO BOX 803, Nevada City, CA, 95959

☐ **Cancellation policy:** Dr. Miller schedules only a limited number of hours each week, and if an appointment is cancelled, time must be available to seek a replacement, which is not always possible at the last minute. Therefore, if you must cancel an appointment, please do so **5 full working days** in advance of the scheduled date, and there will be **no charge for that date**. **A cancellation fee of 50%** will be charged when appointments are canceled with only **3-4 full working days** advance notice. **Full fees will be charged** for any appointment cancelled with **less than 3 full working days of notice**. **Remember, if you cannot keep an office appointment, you have the option of keeping it by phone, Zoom, or FaceTime. Please arrange this in advance by calling (530) 478-1807 extension 1, or (530) 559-9496 in an emergency.**

☐ Contacting Dr. Miller at the time of your appointment:

- **For phone appointments** please call Dr. Miller's appointment line at (530) 559-9496 Nevada City
- **For Zoom appointments** you will receive an invite from Dr. Miller at the time of your appointment via email.
- **For FaceTime appointments** call 530-559-9496.
- **For Skype appointments** connect with emmett@drmiller.com OR live:emmett_180.

☐ **A recording or portion of your session may be made and delivered to you electronically. If you must cancel an appointment, schedule a replacement as soon as possible so as to not lose therapeutic momentum.**

Patient/Client Agreement Letter

Emmett Miller, MD

□ **Fees:** The fee of your visit, $350 per 50-minute hour or the otherwise agreed upon amount of _____ **must be paid at the time of each session.** You may pay by check, VISA, MasterCard, American Express, PayPal, or Venmo.

□ **Insurance: We do <u>not</u>** bill insurance companies directly. A billing receipt (superbill) containing all of the necessary information for your insurance carriers will be given or mailed to you. Attach this receipt to your insurance form and send it to your carrier. Check with your insurance carrier for benefits information, they will inform you as to whether they will reimburse you for your appointment. **If you would like Dr. Miller to provide a diagnosis code to be entered onto your billing receipt, please ask for this after your initial visit.**

□ **Medicare: Are you eligible for Medicare Part B?** □ YES □ NO
We **<u>DO NOT</u> accept Medicare** as payment for services. If you are eligible for Medicare part B you will need to **sign a waiver** stating that you are aware that your visits with Dr. Miller are not going to be billed to Medicare.

□ **Returned checks: A twenty-five dollar ($25.00) fee** will be charged for all returned checks.

□ **Appointment lengths:** One (1) hour appointments are approximately **50 minutes in length** and usually begin on the hour. Two (2) hour appointments are 100 minutes in length. They begin on the hour and end twenty minutes before the end of the second hour. *Arrange if possible for a quiet period* before and after your visit. When a deep meditative, relaxation or hypnotic process has been used, you may need a few minutes to fully reorient. ***Make sure you are fully alert before driving or operating dangerous machinery.***

□ **Scheduling:** Please schedule all future appointments well in advance for a time that is convenient for you. Because the time available each week is limited, **it is best to schedule several appointments at a time** and/or set up a regular, standing appointment time to maintain therapeutic continuity. Please schedule all appointments through Dr. Miller at the time of your visit or call (530) 478-1807, ext. 1. ***Please complete and sign the enclosed Patient Information Form.*** Please return this to the office by mail or email at least 48 hours prior to your appointment.

P.O. Box 803 • PO BOX 803 • Nevada City, CA 95959
(530) 478-1807 Tel • (530) 478-0160 Fax • www.drmiller.com

Patient/Client Agreement Letter

Emmett Miller, MD

Agreement Page

Focus of Treatment:
I understand that Dr. Miller offers counseling, psychotherapy, relaxation therapy, stress management, hypnotherapy, and consultation. I understand that the services he offers are not intended as a substitute for primary medical care, which I will seek from my Primary Care Physician. I also acknowledge that the practice of medicine is not an exact science and that Dr. Miller has made no guarantees to me as to the result of treatments.

Financial Agreement:
I understand that I am financially responsible for all charges whether or not they are covered by insurance. Unless otherwise agreed upon in writing, I agree to pay for each service at the time it is rendered. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize Emmett E. Miller, M.D. to release all information necessary to secure the payment of benefits. For services provided by Emmett E. Miller, M.D., I authorize payment of medical benefits to Emmett E. Miller, M.D.

Insurance Agreement:
If you are accessing your mental health benefits and are a beneficiary of a managed care plan, by signing this statement you give permission to Emmett E. Miller, M.D. to share clinical information as necessary to obtain benefit coverage, whether that is written, telephonic, or by fax transmission. Furthermore, you give permission to Emmett E. Miller, M.D. to mail billing and/or correspondence to your home or office. If you have medical insurance and mental health benefits are not available, or have been exhausted, you are responsible for payment at our usual and customary rate.

Cancellation policy:
If you must cancel an appointment, please do so **5 full working days** in advance of the scheduled date, and there will be **no charge for services**. **A cancellation fee of 50%** will be chargers when appointments are canceled with only **3-4 full working days** advance notice. **Full fees will be charged** for any appointment cancelled with **less than 3 full working days of notice**.

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Patient/Client Agreement Letter

Emmett Miller, MD

Cancellation policy continued:
Remember, if you cannot keep an appointment at the office, you have the option of keeping it by phone, Skype, or FaceTime. Please arrange this in advance by calling (530) 478-1807 extension 1. A recording or portion of your session may be made and delivered to you electronically.

Full Name:_____

Signature: _____

Date: _____

Signature of Parent or Guardian if the patient is a minor:

_____

Authorization to Release Medical Information:
I hereby request and authorize discussion and release of all information including medical records, X-rays, history and findings and prognosis pertaining to the medical condition of services rendered, or treatment given to me by the physicians, healthcare practitioners, hospital, a clinical or medical facility I have identified.

Signature: _____

Date: _____

(signature of patient/spouse/parent/conservator/guardian or patient's representative)

Please return this letter and all forms to us by email (DrMiller@DrMiller.com), fax (530) 478-0160, or mail: PO BOX 803 Nevada City CA 95959

Dr. Emmett Miller, MD
Mind/Body Medicine
EMDR
Stress Management

Patient Health Information

Please print clearly

Nobody likes filling out forms, but your responses to the questions below will save valuable time during our in-person session, and insure that important information will not be missed.

Patient/Client Information **Date** _____
Last Name: _____ **First Name:** _____ **M.I.:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Social Security #: _____ **Age:** _____ **Birthdate:** _____ **Marital Status:** _____
Home Address: _____ **Apt #:** _____
City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Mailing Address ☐ **same as home address**
Street: _____ **Apt #** _____ **P.O. Box** _____
City: _____ **State:** _____
Zip: _____
Fax: _____ **Email Address:**
_____
Occupation/Student: _____ **Employer/School:**
_____
Employer's Address _____ **Apt #:** _____
City: _____ **State:** _____ **Zip:** _____

Family Information:
Spouse's Last Name: _____ **First Name:** _____ **M.I.:** ____
Spouse's Occupation: _____ **Spouse's Work:** _____
Phone: _____
Children (Please include their name/sex/age) _____

If Patient is Under 18 Years of Age:
Mother's Name: _____ **Phone Number:** _____
Father's Name: _____ **Phone Number:** _____
Emergency Contact: Someone who does not live with you
Last Name: _____ **First Name:** _____
Relation: _____
Address: _____ **Apt:** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

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Patient Health Information

What are your desired outcomes or goals of your work with Dr. Miller?

_____
_____
_____
_____

Referral Information (who referred you soon):
Last Name:_____ First Name: _____
Relation:_____ Address:_____ Apt: _____
City: _____State: _____ Zip: _____
May we thank him/her? ☐ YES ☐ NO

Current Medical Information
Primary Care
Physician:_____Speciality:_____
Address:_____Apt: _____
City: _____State: _____ Zip: _____
Phone Number: _____Fax Number: _____ Last Seen:_____

Are you currently undergoing medical therapy? If yes, please complete the following:
☐ NO ☐ YES
Purpose/Diagnosis: _____
Last Name: _____ First Name: _____
Specialty: _____ Address:_____
Apt: _____ City: _____
State: _____ Zip: _____
Phone Number: _____Fax Number:: _____
Last Seen:_____

Are you currently in counseling/psychotherapy or seeing a psychiatrist? If yes, please complete the following:
☐ NO ☐ YES
Purpose/Diagnosis:
_____
Last Name: _____ First Name: _____
Specialty: _____
Address:_____
Apt: _____ City: _____
State: _____ Zip: _____

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Patient Health Information

Phone Number: _____Fax Number:: _____ Last Seen:_____

Have you seen other professionals for this purpose? ☐ NO ☐ YES If yes, please complete the following:
Last Name: _____ First Name: _____
Specialty: _____
Address:_____
Apt: _____ City: _____
State: _____ Zip: _____
Phone Number: _____Fax Number:: _____
Last Seen:_____

Are there any issues or conditions (physical, mental, emotional, social, spiritual, or behavioral) that may have a bearing on what you want to accomplish here?
☐ NO ☐ YES If yes, please explain:

_____
_____
_____
_____
_____
_____

Any prior experience with relationship therapy, biofeedback, hypnotherapy, mediation, or other Mind-Body approaches? ☐ NO ☐ YES
If yes, please describe: _____

Please describe any past hospitalizations, please include dates (except childbirth, tonsils and minor problems)

_____
_____
_____

Phone Number: _____Fax Number:: _____ Last Seen:_____

What is the general state of your health?

_____
_____
_____

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Patient Health Information

Describe any current physical or other health problems:

List all current medications and dosages: (use separate sheet if needed)

How do you rate your diet and nutritional habits? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**
Please describe:

How do you rate your exercise program? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**
What is your routine?

How do you rate your relationships with others? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**
Please describe:

How do you rate your sleep? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**
Quality of sleep?

Number of hours of sleep per night?

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Patient Health Information

Do you use:

☐ **Alcohol** **Amount used:** _____

☐ **Cigarettes** **Amount used:** _____

☐ **Caffeine** **Amount used:** _____

☐ **Other drugs** **Amount used:** _____

Has there been significant alcohol or drug usage in your immediate family or family of origin?

☐ **NO** ☐ **YES** **If yes, please explain:**

_____

_____

_____

Past Health History

Serious Illnesses/Injuries/Surgeries:

Year: _____ **Condition:** _____ **Outcome:** _____
Year: _____ **Condition:** _____ **Outcome:** _____
Year: _____ **Condition:** _____ **Outcome:** _____
Year: _____ **Condition:** _____ **Outcome:** _____

Is there a history of depression or other psychiatric disorder in your family?

☐ **NO** ☐ **YES** **If yes, please explain:**

_____

_____

_____

Allergy Information: List any allergies to medications or significant side effects:

_____

_____

_____

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Patient Health Information

Family Health History:

Father Age Now: _____ State of Health: _____
Age at Death:_____
Significant Illnesses/Cause of Death: _____

Mother Age Now: _____ State of Health: _____
Age at Death:_____
Significant Illnesses/Cause of Death: _____

Brother 1 Age Now: _____ State of Health: _____
Age at Death:_____

Brother 2 Information: What is your brother's age now?:
_____

Brother 2 Age Now: _____ State of Health: _____
Age at Death:_____
Significant Illnesses/Cause of Death: _____

Browther 3 Age Now: _____ State of Health: _____
Age at Death:_____
Significant Illnesses/Cause of Death: _____

Sister 1 Age Now: _____ State of Health: _____ Age at Death:_____
Significant Illnesses/Cause of Death: _____

Sister 2 Age Now: _____ State of Health: _____
Age at Death:_____
Significant Illnesses/Cause of Death: _____

Sister 3 Age Now: _____ State of Health: _____
Age at Death:_____
Significant Illnesses/Cause of Death: _____

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Child 1 Age Now: _____ State of Health: _____ Age at Death:_____
Significant Illnesses/Cause of Death: _____

Child 2 Age Now: _____ State of Health: _____ Age at Death:_____
Significant Illnesses/Cause of Death: _____

Child 3 Age Now: _____ State of Health: _____ Age at Death:_____
Significant Illnesses/Cause of Death: _____