Schelle Cody Miller, Ph.D.

Application for Services
Child Form

Date: _____

Child's Name: _____Date of Birth: _____Age: _____

Gender:_____ Race/ Ethnicity: _____Social Security #:_____

Highest Grade Completed: _____Name of school: _____

Daycare, if any: _____

Who is the primary caregiver? _____

Who has legal custody of the child? _____

Name of the Caregiver with whom child lives:_____

Relationship: _____ Date of Birth: _____Age: _____

Gender:_____ Race/ Ethnicity: _____

Phone Numbers: (Home) _____ (Work) _____(Cell)_____

Mailing Address : _____

City: _____ State _____Zip _____

Street Address, if different from above: _____

_____

Highest Grade Or Degree Completed: _____

If currently a student, list college or school: _____

Occupation: _____Number of Years_____

Marital Status: _____ Number of Previous Marriages _____

Name of other parent or guardian:_____

Relationship: _____ Date of Birth: _____Age: _____

Gender:_____ Race/ Ethnicity: _____

Phone Numbers: (Home) _____ (Work) _____(Cell)_____

Mailing Address (if different from other parent):_____

City: _____ State _____Zip _____

Street Address, if different from mailing address: _____

_____

Highest Grade Or Degree Completed: _____

If currently a student, list college or school: _____

Occupation: _____Number of Years_____

Marital Status: _____ Number of Previous Marriages _____

Please List others who currently live in the home with the child:

Name	Relationship	Age	Gender	Occupation

Please List other family members who do not currently live with the child:

Name	Relationship	Age	Gender	Occupation

Billing Information: **********

Person Responsible for the Bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth:_____

Phone Numbers: Work: _____ Home: _____ Cell: _____

Insurance Company: _____ Phone Number:_____

Policy Holder's name: _____ Date of Birth: _____

Insurance ID# _____ Group # _____

Policy Holder's Social Security Number: _____
(required for billing insurance)
****

Who may I contact in case of an emergency? Name_____

Relationship_____ Number(s):_____

List any major health problems the child has: _____

_____

List Current regular medications: _____

_____

Who is the child's physician_____ Physician's phone #_____

Has the child ever received counseling or mental health services before? _____
If so, please list the counselor(s) or doctor(s) name, city, reason for services, and approximate dates of services: _____

_____

_____

_____

_____

_____

Has the child ever been hospitalized for emotional or mental health reasons?_____
If so, please list the reason for hospitalization, the name of the hospital, city, and approximate dates of services: _____

_____

_____

_____

_____

_____

Why are you seeking services for the child at this time? _____

_____

_____

_____

_____

_____

Who referred you to me, or how did you find me?_____

Who should I call to coordinate treatment / set up appointments for this child?

_____

Contact information:

Is it okay to call them at home? _____ Leave messages at home? _____

Is it okay to call them at work _____Leave messages at work? _____

Is it okay to call their cell phone?_____ Leave messages on it? _____

Where do you want me to mail statements or other necessary letters? _____

Please notify me if your phone numbers, address, or other contact information changes.

The information I have given in this application is accurate and complete. I have the legal right to consent for services for my child, and I am freely seeking professional counseling or psychological services for my child at this time.

Name, Printed: _____Date: _____

Signature: _____

Relationship to child: _____

Note: Except for crisis services, only a custodial parent or legal guardian may consent for services for a minor.

Schelle Miller, Ph.D.

Licensed Psychologist

PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action based on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or unless you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been clearly shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work together will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. The evaluation process involves taking a detailed history, taking information about the current difficulties that brought you in, and sometimes involves some testing (paper and pencil inventories), especially with children and adolescents. During the initial evaluation, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one **50 to 55 minute session** per week at a time we agree on. Over time we may spread the sessions out to every two to three weeks as you being to progress in therapy and feel better. However, scheduling is flexible, depending on your needs. If you need to cancel or change an appointment time, please provide as much notice as possible, at minimum 24 hours notice. When you contact me in advance to cancel an appointment, I will do my best to find another time to reschedule the appointment with you.

MISSED APPOINTMENTS

When an appointment is made, that time is set aside for you and cannot be given to any other client. It is very important that appointments be kept. If an appointment time needs to be rescheduled or canceled, please call the office so that the time may be made available to someone else. We require 24 hours notice of cancellation. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation** [unless we both agree that you were unable to attend due to a genuine emergency]. It is important to note that insurance companies do not provide reimbursement for missed sessions, so **you will be responsible for the $55.00 no-show / late cancellation fee.** Payments for missed appointments are due with the regular fee at the *next* visit. If no-shows or last minute cancellations are excessive, I reserve the right to decline to provide you with further services. If this is necessary, I will provide you with referrals to other competent mental health providers in the area.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone, and do not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a receptionist or by voice mail that is monitored frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you need to reach me due to a mental health emergency (NOT a scheduling issue or a non-emergency question) you may call my cell phone. That number is 615-0028. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911, or go the emergency room at Norman Regional Hospital and ask for the psychiatrist on call. If I will be unavailable for an extended time, such as due to being out of town, I will provide you with the name of a colleague who will be covering my practice.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you

provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I employ administrative staff to assist me with running my practice. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information, and carefully read the section on court testimony on page 6 of this agreement.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Workers' Compensation Court.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a patient has a history of violence and I have reason to believe that there is a clear and imminent danger that the patient will attempt to kill or inflict serious bodily injury upon a reasonably identified person. I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to only what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. EXCEPT in circumstances that involve danger to yourself and / or others, where information has been supplied to me confidentially by others, or if the information has been gathered in a reasonable anticipation of or specifically for use in litigation, you may examine and / or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted, misunderstood, or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so that you can discuss the contents of the records with them. I reserve the right to charge a copy fee of $1.00 for the first page and $.50 cents for each additional page.

PATIENT RIGHTS

HIPPA provides you with several rights regarding your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the HIPPA Notice Form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Both custodial and non-custodial parents are accorded this right under Oklahoma law. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete.

Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern.

Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

PROFESSIONAL FEES

If you have insurance coverage, the cost to you for my services will depend on your insurance coverage and your required copay. My full fee for the first appointment and initial diagnostic evaluation is $185.00. All additional appointments are $135.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include scoring testing that was completed as a part of the initial evaluation, telephone conversations lasting longer than 10 minutes, consulting with other professionals at your request, preparation of records, letters or treatment summaries at your request, and time spent performing any other service you may request of me.

Payment is due at the end of each visit. For minors, it is my policy that the parent or guardian who initiates therapy or testing for a child is the party responsible for the payment at the time that services are rendered. Shared financial arrangements between parents should be worked out between the parents involved.

COURT TESTIMONY AND LEGAL INVOLVEMENT

I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes. My services are limited only to enhancing the health and functioning of my clients. If you are seeking a psychologist who can testify on your behalf, such as in a custody or criminal case, I will be happy to refer you to other psychologists who do provide that service. By signing this agreement and beginning treatment with me, you agree that none of our conversations, treatment, diagnoses, etc. can be used for any legal purposes, and that my records and/or oral testimony cannot be compelled in any case. If a subpoena is issued requiring my appearance or for my records and/or oral testimony, you will then be billed for any attorney fees, costs and or expenses incurred for the time required to comply with or quash the subpoena, and for my time related to dealing with the subpoena. Because of the difficulty of legal involvement, I charge $300.00 per hour of time spent in preparation, travel, consultation, appearance, etc. and require that a retainer be paid in advance.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Most insurance plans require a co-pay for each session. I accept payments by cash, check, and credit card. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, (or if you arrange a payment plan and do not fulfill it) I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. **However, you (not your insurance company) are responsible for full payment of my fees**. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Sometimes insurance companies require additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you a copy of any report I submit to them, if you request it. If your insurance company denies reimbursement, you will be responsible for paying for the services that I provided for you.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

IMPAIRMENT FROM ALCOHOL OR OTHER SUBSTANCES

I respectfully request that you be free of alcohol or other intoxicants prior to coming in for therapy so that we can have the best chance of being successful in our work together. If, during the session, I come to believe that your senses are impaired in some way because of substances, then I will address that concern to determine if we can continue. If in fact you are "intoxicated" for whatever reason, then we will stop the session and I will make arrangements for you to get back to your residence "safe and sound." This may involve calling a friend, relative, or calling a cab. Then too, I will request your car keys so that you will not be tempted to continue driving while impaired. If, for some reason, you refuse to cooperate, then I could be forced to call the authorities to insure your safety and the safety of others. While such a circumstance has only happened one time in my years of practice, you need to be informed about what could happen if you were to come to therapy "impaired" in this way.

PRACTICE STATEMENT:

My office is located in the Aurora Professional Center, a building with several other mental health professionals. This group is an association of independently practicing professionals, which shares certain expenses and administrative functions. While members share office space and expenses, I want you to know that my practice is completely independent in providing you with clinical services.

I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission or in the case of emergency

coverage which you request during my absence. You should be aware that I employ office staff to assist me with running my practice, and I also employ a billing service. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.

BREACH NOTIFICATION ADDENDUM to Policies and Procedures: As required under the 9/2013 Privacy Rule of HIPAA, I must notify you of the following policy. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule.

1. When the Practice becomes aware of or suspects a breach in your PHI, the Practice will conduct a Risk Assessment and will keep written record of that Risk Assessment. This will include reviewing the nature and extent of the PHI involved, to whom the PHI may have been disclosed, whether the PHI was actually acquired or viewed, and the extent to which the risk to the patient has been mitigated.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the practice will give the notice of the breach as described in the breach notification overview in my Privacy Notice.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Your signature on this form indicates that you have read the information in this agreement and agree to its terms. This also serves as an acknowledgement that you have reviewed the HIPAA Privacy Notices form described herein. If you are the guardian or a minor child who is the patient, you are giving legal consent for services for that minor and attest that you have the legal authorization to give consent for the clinical evaluation or treatment for that child.

X_____ _____ _____

Signature of Adult Patient / Guardian Print name of Adult Patient/Guardian Date

_____ _____

Printed name of minor child (if patient is a minor) Date of Birth of Child

I also give permission for Dr. Miller, her staff, or her medical billing company to release medical information to my or my child's (if patient is a child) insurance company or a managed care company contracted by the insurance company to manage medical care if necessary in order for the insurance company to pay their portion of services provided at this office. I further agree to pay for anything that the insurance will not pay for.

_____ _____ _____

Signature of Adult Patient / Guardian Print Name of Adult Patient / Guardian Date

Document revised Apr. 2014