NEW PATIENT INFORMATION FORM

Patient Name: _____ Date of Birth: _____
First Last M.I.

Social Security: _____

Spouse/Guardian (if applicable): _____ Date of Birth: _____
First Last M.I.

Social Security: _____

Patient Marital Status:
□ Single
□ Live Together/Married
□ Divorced
□ Widowed

Home Address: _____ Home/Cell Phone: _____

_____ Okay to leave a message? □ Yes □ No

Employer Name: _____ Work Phone: _____

_____ Okay to leave a message? □ Yes □ No

Primary Insurance: _____ ID Number: _____

Telephone: _____ Group Number: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Please describe the current problem in your own words, as specifically as possible:

How long has this problem existed or when did you first notice it?

Dr. Jeanne M. Miller, Ph.D.
Licensed Clinical Psychologist
Licensed Professional Counselor

801 Franklin St., Alexandria, VA 22314
Office Phone: 703-795-7929
Updated 08/25/2017

Please circle all words/phrases that you are currently experiencing:

Problems with alcohol or drugs	Overuse of Internet, pornography, shopping, exercise, gaming, gambling, spending	Anger/Irritability	Depressed/Sad/Down
Crying Spells	Too Much Energy	Loss of Interest in things that used to make you happy	Difficulty enjoying life
Decreased Motivation	Withdrawal/Isolation	Mood Swings	Trouble Sleeping (can't sleep or sleeping too much)
Weight gain or loss without trying	Cutting/Burning	Thoughts of wanting to hurt yourself/die	Thoughts of wanting to hurt someone else
Feeling hopeless or worthless	Feelings of shame/guilt	Low Self-Esteem	Anxious/Nervous/Tense
Panic attacks	Racing Thoughts	Obsessions	Flashbacks or Nightmares
Hearing or seeing things other people don't	Uncontrollable need to check locks/stove/doors, wash hands, count things, germ fears	Perfectionism	Rules about eating/fear of gaining weight
Past or current sexual or physical abuse	Physical Symptoms	Other: _____	

Have you ever had psychotherapy in the past? □ Yes □ No If Yes, when _____

If yes, what was most helpful?_____

What was least helpful?_____

Have you ever been hospitalized for psychological treatment? □ Yes □ No

Have you ever been hospitalized for medical treatment? □ Yes □ No

Have you ever had a head injury? □ Yes □ No

Please list all current prescribed and over the counter medications:

_____

_____

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT
Please read and sign at the end stating you have fully read and understand the information below.

AVAILABLE SERVICES: I am able to provide a wide array of counseling and psychotherapy services and treatments including individual, couples, and family therapy in short and long term formats, designed to address a wide variety of clinical issues and problems in living. **I DO NOT conduct disability assessments OR fill out disability paperwork.**

RISKS AND BENEFITS: Counseling and psychotherapy can be very beneficial, but as with any treatment, there are inherent risks. During therapy, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. In general, the benefits of therapy can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. Therapy cannot guarantee these benefits, however, and a large part of what you get out of therapy will depend on the effort you are willing to put into therapy.

My goal is to provide the most effective therapeutic experience available to you. If at any time you begin to feel that we are not a good fit, please discuss this matter with me and together we will determine how best to resolve the situation, up to and including referral to another therapist if needed. You have the right to ask questions at any time during therapy. I will always be willing to discuss how and why I suggest any given intervention and to look at alternatives that might work better. You can also feel free to ask me to try something that you think will be helpful. You are free to leave therapy at any time. This is your therapy.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are between 45 and 60 minutes long. In order to gain the greatest benefit from treatment, it is important to attend scheduled therapy sessions. *Your appointment time is reserved especially for you.* If you must cancel or reschedule your appointment, please call the office at **(703) 795-7929 AT LEAST** 24 hours in advance. No Shows or appointments missed with less than 24 hours' notice will be charged full fee. **This charge is not covered by insurance**. If you miss three appointments in a row, or three appointments out of any four scheduled, I may give your reserved appointment time to someone else and offer you a different appointment. If a pattern of missed appointments/late cancellations emerges, or if you are regularly unable to arrive on time for your appointments, we may have to discuss suspension of treatment and/or referral to another provider. If, during the course of treatment, it becomes clear to me that you would better benefit from another form of treatment, I will refer you to a provider who is qualified to perform said treatment if it is not within my scope of practice.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$150.00 - $175.00
	Regular Office Visits	$150.00
	Returned Check	$35.00
	Late Cancel/No Show	$150.00
	Depositions/Court Appearances	$150.00/hr
	Copies will be charged based on time and number of copies requested	

I raise my session and evaluation fees every five years. The next fee increase is scheduled for January 1, 2018.

PAYMENT/INSURANCE FILING: If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a patient imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not in your network. Such firms also occasionally require reports of your progress in therapy, and on rare occasions, copies of your case file. I do not have control over any aspect of their rules. If you are not using an insurance plan or wish to see me as an Out-of-Network provider, full payment is expected at the time of service, and I will provide you with a statement for services rendered which you may submit to your insurance company.

Payment of fees, including any required co-pay, is expected at the time of each appointment. Completing payment before your session begins is preferred. It is your responsibility to check with your insurance company to verify your benefits and comply with any requirements for pre-authorization for services (e.g., referral from your primary care physician). By signing this statement, you are agreeing to full responsibility for any co-pay, co-insurance, deductible, or other fees not covered by your insurance. I reserve the right to employ a collections agency for any unpaid balance.

EMERGENCIES: You may encounter a personal emergency which requires prompt attention. If you are experiencing a life threatening emergency, please call 911 or have someone take you to the nearest emergency room for help. Please contact me as soon as possible after going to the hospital and I will make every effort to schedule you an appointment as soon as possible or to offer other options. Because patients may be scheduled back-to-back, it is not always possible to return a call immediately. I will make every effort to respond to your emergency in a timely manner however PLEASE DO NOT WAIT FOR ME TO CALL YOU BACK before going to the hospital.

CONFIDENTIALITY: This office follows all ethical standards prescribed by state and federal law. Although I am required by practice guidelines and standards of care to keep records of your therapy, discussions between a Therapist and Patient are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations:

If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 24 hours and Adult Protective Services immediately. If you are between the ages of 16 and 18 and you tell me that you are having sex with someone more than five years older than you, or sex with a teacher or a coach, I must also report this to CPS, even though at age 16 you have the right to consent to sex with someone no more than five years older than you. I would inform you before I took this action.

If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. Please know that I would explore all other options with you before taking this step.

If, in the course of couples' therapy, you and your partner have some individual sessions as part of the couples' therapy, what you say in those individual sessions will be considered to be a part of the couples' therapy. If information you share during your individual sessions is relevant to the couples' therapy, it is highly probable that I will encourage you to discuss this information in some future couples' session. I will remind you of this policy before beginning any such individual sessions.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

Please be advised that if you elect to communicate with me by email that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Sensitive information is best shared face to face during therapy sessions.

If you have any questions regarding confidentiality, please discuss them with me. By signing this Information and Consent Form, you are giving your consent for me to share confidential information with all persons mandated by law and with the agency that referred you and with the insurance carrier responsible for providing your mental health care services and payment for those services.

CONSENTS:

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I am (or my child if child is the Patient) in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of my Therapist, my Therapist has made provisions to safeguard the confidentiality of my file including, but not limited to, transferring possession of my file to another licensed mental health professional or employing someone equally bound by confidentiality to maintain the security and continued existence of my file as required by law.

CONSENT TO TREATMENT: By signing this Psychotherapy Information Disclosure Statement as the Patient or Guardian of said Patient, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to ask any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment, and services for me (or my child if said child is the patient), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to the treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, no services will be rendered until the Therapist has received and reviewed a copy of the most recent applicable court order.

Signature - Patient/Parent	**Date**
Signature – Spouse/Partner/Parent	**Date**
Therapist	**Date**

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

Signature - Patient/Parent	**Date**
Signature – Spouse/Partner/Parent	**Date**

I hereby authorize the payment of medical benefits to the provider of services.

Signature - Patient OR Patient's Legal Representative	**Date**

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI maintained at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED OR USED:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services, provided I have a written contract with the business that requires it to safeguard the privacy of your PHI). For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

FOLLOWING IS A LIST OF THE CATEGORIES OF USES AND DISCLOSURES PERMITTED BY HIPAA WITHOUT AN AUTHORIZATION:

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

1. Required by law, such as the mandatory reporting of child, elder, or incapacitated adult abuse or neglect, or mandatory government agency audits or investigations (such as the psychologist licensing board or health department).
2. Required by Court Order.

3. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization. I will not disclose your information to family members without your written authorization except as provided for above. Other uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked in writing at any time.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI maintained by this office. To exercise any of these rights, please submit your request in writing to Dr. Jeanne M. Miller, Ph.D. at 801 Franklin St., Alexandria, VA 22314.

1. **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable fee for copies.
2. **Right to Amend.** If you believe that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment.
3. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment of health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
5. **Right to Request Confidential Communications.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
6. **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
7. **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me, Dr. Jeanne M. Miller, Ph.D., at 801 Franklin St., Alexandria, VA 22314, or with the Secretary of Health and Human Services at 200 Independence Ave., Washington, DC 20201, or by calling 1-877-696-6775. **There will be no retaliation against you for filing a complaint.**

Signature - Patient/Parent	**Date**
Signature – Spouse/Partner/Parent/Legal Representative	**Date**
Therapist	**Date**