Jennifer A. Miller, Psy.D.

Licensed Clinical Psychologist
PSY17908

CONFIDENTIAL PERSONAL INFORMATION (Please Print)

Today's Date ______________________ Home Phone ___________________________ Cell/Other Phone _____________________

Patient's Name____ Sex: Male Female

Street Address ____ Age ____________

City ____ State _________________ Zip ___________________

Social Security # ___________________________ Driver's License # ________________________ Birthdate __________________

Place of Birth (City/State/Country) ____

Occupation/School ____ Business Phone ____________________________

Your Employer____

Employer's Address ____

City ____ State __________________ Zip ___________________

Marital Status: Single Married Separated Divorced Widowed

Spouse (or Responsible Party/Parent) Name: _______________________________________ Relationship ______________________

Occupation ____ Birthdate ____________________

Employer ____ Business Phone ____________________

Employer Address ____

City ____ State __________________ Zip ___________________

In case of emergency, please notify ____ Relationship ______________________

Address ____ Phone __________________________

Family Physician's Name ____

Address ____ Phone __________________________

Referred by ____

AUTHORIZATION TO TREAT:

I authorize and direct **Jennifer A. Miller Psy.D.** to perform such therapeutic procedures that their professional judgment may indicate to be advisable for the well being of myself, my child and/or my family. I understand that no warranty or guarantee is made as to the results of this treatment. I also understand the Triwest/Champus and most insurance companies do not pay for missed appointments, and **I agree to assume financial responsibility for the regular fee charged for a failed appointment canceled with less than 24 hours notice**.

Date ______________________________________ Signed ____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or mental health benefits, to include major medical benefits to which I am entitled, including Triwest/Champus, and other government sponsored programs, private insurance, and any other health plans to **Jennifer A. Miller, Psy.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance**. I hereby authorize said assignees to release all information necessary to secure payment.

Date ______________________________________ Signed ____

If you are covered by any insurance plan, please complete the NEXT PAGE: **INSURANCE VERIFICATION**

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