# PATIENT INFORMATION SHEET

**RACHEL MILLER, PSY.D., PLLC**
LICENSED CLINICAL PSYCHOLOGIST
1350 CONNECTICUT AVENUE, NW, SUITE 1225
WASHINGTON, DC 20036
(202) 558-6800

*Welcome. Please complete as much or as little of this form as you like.*

Name: _____ DB: _____ Age: _____

Local Address: _____

Birthplace: _____ Hometown: _____

Preferred Phone: _____ Cell Home Work OK to leave msg? Y N

Secondary Phone: _____ Cell Home Work OK to leave msg? Y N

Email address (only used with your permission): _____

Social Security Number: _____ Cultural/Ethnic background: _____

Emergency Contact (name, phone, relation): _____

Health Insurance Carrier: _ _____ Member ID#:_____

Who referred you?: _____

**FAMILY:** Please list all family members and any significant others. Please include: Name, Relationship to you, Age, Location, Occupation, and any Mental Illness.

_____

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**EDUCATION AND EMPLOYMENT**: Please list current and recent significant **employment** (position, company, location, and time frame), and **education** (school, degree, location, and time frame).

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**HEALTH**: Please list Significant Medical History (chronic conditions, accidents, major illnesses, surgeries): _____

_____

Current psychiatrist: _____ Current psychiatric medication: _____

Past psychiatric medication: _____

Other current medication: _____

**PREVIOUS PSYCHOLOGICAL TREATMENT** (please list all past psychological treatment, including any hospitalizations; including reasons, location, and time frame): _____

_____

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_____

**CURRENT MENTAL HEALTH**: Please check all of the following items which are concerns at this time, and circle those which are most important.

| | | | |
|---|---|---|---|
| ___Abortion issues | ___Divorce, separation | ___Legal problems | ___Self-injury, mutilation |
| ___Abuse – emotional, physical | ___Drug use | ___Loneliness, no friends | ___Self-neglect, poor self-care |
| verbal, sexual, neglect | ___Eating problems | ___Memory problems | ___Sexual assault |
| ___Academic issues | ___Emptiness | ___Mood swings | ___Sexual concerns |
| ___Advisor/faculty concern | ___Family relationships | ___Motivation | ___Sexual harassment |
| ___Aggression/violent behavior | ___Fearing failure | ___Overly responsible to others | ___Sexual orientation/identity |
| ___Alcohol use | ___Fears, phobias | ___Overly sensitive to rejection | ___Sexually transmitted disease |
| ___Anger, arguing | ___Financial problems | ___Panic attack | ___Shame |
| ___Anxiety, nervousness | ___Gambling | ___Perfectionism | ___Shyness, oversensitive |
| ___Body image | ___Guilt | ___Peer relationship concerns | ___Smoking, tobacco use |
| ___Career concerns, choices | ___Harassment | ___Pregnancy | ___Sleep problems |
| ___Childhood issues (yours) | ___Health, medical concerns | ___Prejudice/bias concerns | ___Stress |
| ___Children/parenting concerns | ___Hallucinations | ___Procrastination/time mngt. | ___Suicidal thoughts |
| ___Compulsive behaviors | ___Identity issues | ___Racial/ethnic concerns | ___Tiredness, fatigue |
| ___Computer excessiveness | ___Impulsive, out of control | ___Repeated troubling thoughts | ___Violent thoughts |
| ___Concentration | ___Independence from parents | ___Relationship concerns | ___Withdrawal, isolating |
| ___Decision making, indecision | ___International student concern | ___Relationship violence | ___Worthless feeling |
| ___Grief issues | ___Irresponsibility | ___Religious/spiritual concerns | ___Other |
| ___Depression, sadness, crying | ___Learning disability | ___Romantic relationship | |

Signature _____ Date _____

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# PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. I appreciate your trust and the opportunity to assist you. I am providing you with the following information to answer many of the questions people typically have when beginning psychotherapy, and to outline policies and procedures that are specific to my work. If you have any questions, thoughts, or feelings about what is printed, please feel free to discuss them with me in our sessions. When you sign this document, it will represent an agreement between us.

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 new federal law that provides new privacy protection and new 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, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

## Psychotherapy

The benefits of therapy have been repeatedly and scientifically demonstrated for most people in most situations. Depending on your initial issues and symptoms, benefits might include the lessening of depressive symptoms or feeling less afraid or anxious. You may experience an increased sense of well-being and comfort with yourself. With a more thorough understanding of yourself, you are likely to be able to make changes that enhance your family or social relationships and find deeper satisfaction in them. Through the therapeutic process, you may come to better understand your personal goals and values, growing and maturing as an individual.

As with any treatment, there are both risks and benefits associated with psychotherapy. The risks of therapy can include an exacerbation of symptoms, new symptoms, the questioning of beliefs and values, possible changes in lifestyle, relationships, or employment. Other risks can include the experience of intense and unwanted feelings (including sadness, anger, fear, guilt, or anxiety) as you begin the healing process. However, these feelings may be a natural, normal, and important part of your therapy. Other risks might include recalling unpleasant life events, facing difficult thoughts and beliefs, and changes in your relationships. During our work, I hope to discuss any of your reactions to or adverse side effects of your therapy.

Our work will end once you are satisfied with your progress and we discuss this and how we will end. You may also decide to terminate our work for other reasons, but I encourage that we meet for at least one more session to discuss the ending. In addition, Ethical Standards dictate that I should terminate therapy when I do not feel it is being helpful, and if I do so, I will be sure to provide you with appropriate referrals.

## Meetings

My services are by appointment only. I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, 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 45-minute session per week at a time we agree on, although some sessions may be more frequent. Due to the nature of psychotherapeutic work, I must adhere firmly to time guidelines. As such, if you are late for a scheduled session, it will end at its regularly scheduled time. If I am late for a session, I will either make up the lost time or adjust the fee accordingly.

## Cancellation Policy

In the event that you need to cancel an appointment, please let me know as far in advance as possible, but at least 48 hours ahead. **Because the appointment time is reserved for you, it is necessary to charge for appointments which are not cancelled 48 hours in advance.** Please remember that insurance companies typically do not reimburse for cancelled sessions. If you would like to reschedule a cancelled session during the same week, I will attempt to accommodate your request.

**Telephone and Emergency Policy**
If you need to reach me between regularly scheduled appointment times, you can call me at (202) 558-6800. The voicemail at this number is confidential. I check these messages regularly and will return your call at the earliest possible opportunity. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**Billing and Fees**
I charge an hourly rate for each 45 minute session. **I require payment at the time of service.** At the end of each session, I will provide you with a bill detailing the service provided and the total amount paid. (Please note that returned checks are subject to a $25.00 fee). If this billing arrangement is not feasible, I ask that you discuss this with me to work out an agreeable arrangement. If the bill is two months overdue, I reserve the right to discontinue therapy until you pay the full amount. If you cannot, I will refer you to an inexpensive alternate source of help, if necessary.

**Insurance Reimbursement**
If you plan to use out-of-network mental health coverage, I will fill out any necessary forms required of me and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you (and not your insurance provider) are ultimately responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

**Professional Records**
The laws and standards of my profession require that I keep Protected Health Information about you in your clinical record. Except in unusual circumstances, you are entitled to receive a copy of your records if you request it in writing Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers; therefore, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

**Patient Rights**
HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled "Notice of Policies and Practices to Protect the Privacy of Your Health Information" lists these rights.

**Confidentiality and Privacy of Information**
I will make every effort to safeguard the privacy of information concerning our work together. It is a violation of the District of Columbia Mental Health Information Act of 1978, as well as the Ethical Principles of the American Psychological Association, to disclose any information regarding the treatment of clients.

There are several specific exceptions to the rule of confidentiality. These are listed below:

- You may authorize me to release records or other information to individuals of your choosing. I may only do this with your expressed written consent.
- Under ethical and legal requirements, I may be required to break confidentiality in the event of a clear and imminent danger to yourself or another person.
- In the event that you disclose information that provides evidence of current abuse or neglect of minor children or a vulnerable adult, the law may require that I make a report to the appropriate state agency.
- In certain legal proceedings, confidential information may be disclosed by court order. This is a rare occurrence and would not happen without your knowledge.

**Minors and 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. The effectiveness of psychotherapy depends on the patient's sense of trust and safety in the therapeutic relationship so that the patient is willing to honestly address problems. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to request an agreement from any patient between 15-18 and his/her parents allowing me to share general information about the progress of treatment and their child's 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.

**Acknowledgement**

**Your signature below indicates that you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA notice form "Notice of Policies and Practices to Protect the Privacy of Your Health Information."**

Name of Patient: _____

Signature of Patient: _____ Date: _____

If minor, Guardian's Signature: _____ Date: _____

Signature of Therapist _____ Date: _____
Rachel B. Miller, Psy.D.

Please return this signed consent form to me. I will provide you with a copy for your records. Thank you.