DAVID B. MILLER, PSY.D., P.A.,

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Referred by:_____ Date_____
Name:_____ Date of Birth_____
SS Number: _____ Age____ Marital Status_____
Home Address_____
City_____ State_____ Zip_____ Spouse's Name_____
Home # ( )_____ Cell # ( )_____ Work # ( )_____
Family Physician:_____
Present Medications_____
Emergency Contact_____ Relationship_____ Phone ( )_____

AS A PATIENT OF DR. MILLER'S, SPECIFIC MUTUALLY AGREED UPON APPOINTMENT TIME(S) WILL BE RESERVED FOR YOU WEEKLY. THEREFORE, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THAT BLOCK OF TIME AND WILL RECEIVE A STATEMENT AT THE END OF THE MONTH.

DR. MILLER IS NOT A PARTICIPATING PROVIDER WITH ANY INSURANCE COMPANIES and Does Not Accept Credit/Debit Cards. Check or Zelle Is Acceptable.

I,_____ understand that I am financially responsible for all fees for services rendered. If applicable, I authorize treatment for my minor child,_____.

Signature_____ Date_____

I agree and understand that it is the policy of Dr. Miller's office to turn over all unpaid balances to a collection agency or attorney after a period of 60 days. I agree to pay any collection costs and/or attorney's fees if my delinquent balance is placed with an agency of attorney for collection or suit.

By signing this financial consent, you are acknowledging that you have read, understood and agreed to its terms and are authorizing the office to release all necessary information to secure payment.

Signature_____ Date_____

I have read the Florida Notice Form (HIPPA) and understand my rights. Please initial___