Please fill out the following forms as completely as possible and return as an attachment to a Luminello message to Dr. Miller.

Brandon J. Miller, M.D.
1304 W Walnut Hill Ln. Suite 100
Irving, TX 75038
Phone: 469-941-0444

CHILD'S INFORMATION Date: ___/___/___

Child's full name:______________________ Birth Date: ___/___/___ M/F: ___

PERSON ANSWERING QUESTIONS

Name:______________________ Relationship to child: ______________________

REFERRAL INFORMATION

Referral Source:__________________ Primary Care Physician:__________________

CUSTODY AND PRIMARY CAREGIVER

Who has legal Custody of this Child?____________________________

_____Temporary ____Permanent Telephone Number (___)_________

Does the child have a biological parent not living with the child? ___No ___Yes

If yes; is there visitation and how frequent: ______________________________

CHILDCARE

Who cares for the child when caregivers are working?

____

HOUSEHOLD MEMBERS (List all people living in the home)

Name	Age	(M/F)	Relationship to Child

PARENTS

Mother's Name: ______________________ Location if not living with child: ______

Occupation: ____________________ Highest Grade Completed: ______________

Father's Name: ______________________ Location if not living with child: ______

Occupation: ____________________ Highest Grade Completed: ______________

Family Losses (death, separation, etc.): ____ No ____ Yes, if "yes," please explain ______________

PREVIOUS PSYCHIATRIC TREATMENT

Name of Previous Provider: (Psychiatrist or Therapist)	Reason	When

Previous Hospitalizations or Residential: Location	Reason	When

PREVIOUS PSYCHIATRIC MEDICATIONS

Please list all medications, dosages, how it helped, side effects if any, and why stopped

____

____

____

____

____

Please List History of Suicidal Thoughts, Attempts, or Self-harm (cutting, burning, etc.)

____

ALCOHOL, DRUG, LEGAL & ABUSE HISTORY

Cigarettes or chewing tobacco: ____ No ____ Yes

Beer, wine, liquor: ____ No ____ Yes

Marijuana: ____ No ____ Yes

Methamphetamines or cocaine: ____ No ____ Yes

Huffing or sniffing: ____ No ____ Yes

Prescriptions (pain killers, benzo's i.e. Xanax): ____ No ____ Yes

Been Arrested: ____ No ___ Yes

Appeared in Juvenile Court: ____ No ___ Yes

Involved with Child Protective Services (CPS): ____ No ___ Yes

Involved in custody dispute: ____ No ___ Yes

Please describe any "Yes" answers

____

____

CHILD'S MEDICAL HISTORY

Please list any significant illnesses, hospitalizations or surgeries: (include heart, head injuries, seizures, obesity, diabetes, lung, stomach, bowel, serious infections or ingestions, i.e. lead poisoning)

____

____

CURRENT MEDICATIONS	Dosage	Time Given

ALLERGIES TO MEDICATIONS AND REACTION

____

CHILD DEVELOPMENT AND EDUCATION

Duration of pregnancy: ____ Full term ____ Pre-mature Weight: ____ lbs. ____oz

Complications during pregnancy: ________________________________

Medications used during pregnancy: ________________________________

Tobacco, Alcohol, or other drug use during pregnancy: ________________________________

Complications during delivery: ________________________________

DEVELOPMENTAL MILESTONES (approximate age)

_____ Crawling
_____ Say 1st word
_____ Walking
_____ Two word phrases
_____ Potty trained (urine)
_____ Potty trained (bowel)

CURRENT DIFFICULTIES

____ Hearing
____ Speech delay
____ Excessive crying
____ Vision
____ Stuttering
____ Temper tantrums
____ Feeding/Eating
____ Pronunciation
____ Separation from parents
____ Failure to thrive
____ Making friends
____ Cannot sleep alone
____ Bed wetting
____ Daytime bladder/bowel
____ Sibling Relations

CHILD'S SCHOOL HISTORY

Current school and grade. ________________ School problems: ____________________

Has child received. ___ ECI ___ PPCD ___ Speech therapy ___ OT ___ PT ___ Reading program

Retained in school: ___ No ___ Yes. what grade(s):________ 504 plan ___ No ___ Yes

Qualified for Special education: ___ No ___ Yes, type of services: ____________________

FAMILY HISTORY

Please list psychiatric diagnosis in family members: (depression, anxiety, ADHD, bipolar, psychosis, etc.)

Also include history of medication, psychiatric hospitalization, suicide attempts or completions

____

____

____

Please list family members with history of alcohol or drug abuse

____

Please list significant medical history of close family: (heart disease, diabetes, seizures, etc.)

____

Please list history of legal, incarceration or violent behavior in family members.

____

________________________ ________________________

Parent Signature

Physician Signature / Date

Welcome to DFW Child Psychiatry. Your agreement to the following terms and conditions is required for you/your child to receive professional services.

Clinical services

You consent for yourself/your child to receive a comprehensive diagnostic assessment. At the end of the evaluation, we will mutually decide if we will continue treatment together.

Please note that we do not have admitting privileges at any hospital. We are not affiliated with or on staff at any hospital. Should we deem that more intensive services are needed than we can provide on an outpatient basis, we will do our best to ensure safety and recommend the appropriate level of care. We cannot provide that care directly and cannot guarantee the receipt or quality of care that others provide.

If there is a potential of any physical danger to you, your child, or others, you will call 911 immediately or go to the closest emergency room. To reach me outside of standard business hours, follow the instructions on my voicemail.

You agree to keep follow up appointments as scheduled.

You agree to receive appointment email and phone notifications to email address and phone numbers on file. You can change these at any time through the Luminello portal.

Confidentiality

There is no guarantee of confidentiality under the following conditions:

- If we suspect you/your child are/is in imminent danger of harm to self or others, or a child or elderly person is being abused or neglected
- If you initiate a billing dispute with a financial institution
- If your insurance company requests to review your/your child's case
- If you pay by credit card, Ilianai Torres-Roca MD or DFW Child Psychiatry, will appear on your credit card statement
- If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collections agency or other responsible party
- Between me and my administrative/billing staff.

Payment

You agree to pay professional fees as follows:

In-network services

I will submit claims on your behalf as a courtesy, but there is no guarantee that your insurance will pay. You are financially responsible for full payment, whether your insurance company pays partially, or not at all, for services rendered.

You affirm you are an authorized user of the credit card number and expiration date supplied, and you do authorize its use for all fees incurred not covered by insurance.

Private pay/out of network fees:

Initial evaluation: $400
Follow up appointments: $195

______________________	______________________
Patient Name	Date of birth
______________________	______________________
Legal guardian name	Relationship to patient
______________________	______________________
Guardian signature	Date

No Show/Late Cancellation and Other Office Policies

- If you are unable to keep your appointment, please cancel with at least **2 business days advance notice**. For example, if you or your child's appointment is on Monday, you will communicate your cancellation no later than the previous Thursday. If an appointment is on Tuesday, you will communicate your cancellation no later than the previous Friday.

- If you do not cancel your appointment with at least **2 business days advance notice**, you will be charged a **$75 no show/late cancellation fee**.

- No show/late cancellation fees are not covered by insurance.

- After **3 missed appointments** any future no show or late cancelled appointments will have a $195 fee.

- There is $50 fee for letters or paperwork completed by Dr. Miller. Please expect 3-5 business days for letters or paperwork to be completed.

- Please notify our office of any **insurance changes** at least a week prior to your appointment.

By typing your signature below, you confirm you have read the above and agree to these terms and conditions.

______________________________ ______________________________

Patient Name Date of birth

______________________________ ______________________________

Legal guardian name Relationship to patient

______________________________ ______________________________

Guardian signature Date

Brandon J. Miller, M.D.

1304 W Walnut Hill Ln, Suite 100
Irving, TX 75038
(469) 941-0444

Section I: Patient Information

Date ____________________

Name: ____ Date of Birth ________________ Age: __________

Address: ____________________________City:________________ State: __________ Zip: ____________

Phone: ________________________________ Email: ____________________________________ By applying email you are giving consent to email you.

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If parents are divorce or if applicable please provide custody/guardianship documents.

If Minor: Please provide Mother and Father's (or legal guardian's) Information

Mother: ________________________________ Phone: ____________________________ DOB:__________

Father: ________________________________ Phone: ____________________________ DOB:__________

Referral Source: ____

Is it okay if we contact you and leave messages at the above emails and phone numbers? If it is please sign the line below. If it is not, please let the receptionist know.

____

Name:____ Relationship to Patient:__________________________

Section II: Responsible Party Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ____ DOB: ____________________________

Address____

City: ____________________________ State:________________ Zip:__________

Phone:____ Cell Phone: ______________________________

Employer: ____

Part III: Insurance Information

Name Primary Insured: ________________________ DOB: __________ Relation to Patient: __________

Insurance Company Name: ________________________________ Phone Number: ____________________

Member ID: ____ Group#:________________________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, ASK THE RECEPTIONIST FOR AN ADDITIONAL FORM.

Notice of Privacy Practices for Brandon Miller, M.D.

To our patients: this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information is certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request

that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Miller. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office at 469-941-0444. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office at 469-941-0444.

I,_________________________________authorize Dr Miller's office to release information to the following individuals.

Name:_________________________Relationship:_____________Phone:______________

Name:_________________________Relationship:_____________Phone:______________

I hereby acknowledge that I have been presented with a copy of Dr Miller's Notice of Privacy Practices.

Signature:____

Date:____

Name of patient:______________________________________

DFW Child Psychiatry

1304 W. Walnut Hill Lane, Suite 100

Irving, Texas 75038

Credit Card Authorization

I am authorizing DFW Child Psychiatry to have my credit card information on file.

This credit card will only be used to charge fees due at this office.

I can remove the credit card from the system at any time through the patient portal.

______________________________	______________________________
Patient Name	Patient Date of Birth
______________________________	______________________________
Signature/Parent or Guardian	Name of Parent or Guardian