Brady M. Miller, Ph.D.
915 118th Ave SE - Suite 285
Bellevue, WA 98005
Phone 425-224-5775

Date: _____

Client Name: _____ Reliable Phone #: (_____) _____-_____

Client SSN: _____

Home Address:

_____

(Street) (City) (State) (Zip Code)

Birth Date: _____ Highest (or current) Education Level: _____

Caregiver(s) Name(s) (if minor):

_____

Relationship to Client: _____

Employer (or School if minor): _____

Work Phone: (_____) _____-_____

Contact in case of emergency: _____ Phone: (_____)_____-_____

Relationship to client: _____ Referral Source: _____

Preferred meeting days/times:

_____

Medical History

Physician: _____ Phone: (_____) _____-_____

Medications & other substances currently being taken & current dose/frequency:

_____

_____

All significant medical conditions & hospitalizations

_____

_____

Reason for consultation: _____

_____

Insurance Company: _____ (___Indemnity) (___PPO) (___HMO)

Group Number: _____ ID Number: _____

Claims Address: _____

***Subscriber Date of Birth**: _____

MY SIGNATURE BELOW REPRESENTS MY "SIGNATURE ON FILE" AT THE OFFICE OF DR. BRADY M. MILLER AND IS TO BE USED IN PLACE OF AN ORIGINAL SIGNATURE ON INSURANCE FORM OF FOR PERMISSION TO BILL AND FOR THE ASSIGNMENT OF BENEFITS TO BE PAID TO DR. MILLER. THIS SIGNATURE ALSO REPRESENTS PERMISSION TO RELEASE TO MY INSURANCE COMPANY ANY ESSENTIAL INFORMATION WHICH IS NECESSARY TO INITIATE OR MAINTAIN THE CONTINUITY OF MY HEALTH BENEFITS. THIS WILL ALSO APPLY TO MY DEPENDENT FAMILY MEMBERS.

_____ _____

Date Signature of Patient (or Legal Guardian)

Brady Miller Psychology, PLLC
Licensed Clinical Psychologist PY 60200533
915 118th Ave SE - Suite 285
Bellevue, WA 98005
425-224-5775 Phone

Consent to Use and Disclose your Health Information

This form is an agreement between you, _____ and Dr. Brady Miller (Brady Miller Psychology, PLLC). When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here:

_____.

When we examine, evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website: bradymillerphd.com or from our compliance officer (Dr. Brady Miller) who can be reached at 425-224-5775 or at the address above.

After you have signed this consent, you have the right to revoke it by writing to our compliance officer, Dr. Brady Miller. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of legal representative Relationship to Client

_____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

☐ Copy given to the client/parent/personal representative Date _____

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Statement of Fees
Effective August 1, 2017

Initial Diagnostic Interview Examination (90 minutes)	$225
Individual Psychotherapy (45 minutes)	$160
Extended Sessions (53-60 minutes)	$185
Family Psychotherapy (45 minutes with or without patient)	$160
Missed sessions/Late cancellations *Not billable to Insurance*	$160

Your fees after insurance may be different than those shown above, and you are responsible for verifying all benefits and copayments/coinsurance. You are responsible for all deductible amounts, co-insurance/co-pay amounts at the time of session. Regardless of your insurance provider and your contract with them, you remain ultimately responsible for all charges. *Dr. Miller's insurance network participation is subject to change and you will be notified as early as possible prior to such a change.* All rates are subject to increase with 60 days notice.

Phone messages will ordinarily be returned during the office hours of 8:00 AM to 5:00 PM Monday through Friday. If you call after hours, your call will be returned the next business day. If you have an emergency and are unable to attend the scheduled meeting time, please call more than 24 hours in advance of your session time to avoid a missed session fee. Please sign up for free session reminders on bradymillerphd.com under "reminders." If you are feeling physically ill, please call by 9:00 am on the day of session to cancel and avoid a missed session charge. Missed sessions or cancellations less than 24 hours prior to session time are subject to the full fee above.

Any balances older than 60 days without a written payment plan in place are subject to a 1.5% late fee per month. Balances older than 90 days will be referred to external collections.

By signing below, you are accepting responsibility to pay for Dr. Miller's services & consenting for Dr. Miller and/or his billing agent to bill your insurance. This represents your "signature on file" for billing purposes.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Dr. Brady Miller Date

Brady Miller Psychology, PLLC
Licensed Clinical Psychologist PY 60200533
915 118th Ave SE - Suite 285
Bellevue, WA 98005
425-224-5775 Phone

For each of the following sections, please initial or have your legal guardian initial to signify that you (or your legal guardian as applicable) have carefully read, understand and accept all sections. "You" refers to the client or legal guardian and "I" or "me" refers to Dr. Brady Miller.

_____ **Consent to Psychological Services** In Washington State, any individual 13 years of age or older (including unemancipated minors 13 years of age or older) must provide consent for psychological services.
RCW 71.34.530 Any minor thirteen years of age or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a parent who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

_____**Appointments**: Standard appointments are 45 minutes in length. Sessions lasting 53-60 minutes will be billed at a higher rate. Your appointment will end at the originally scheduled time regardless of your arrival time. Session times fill up 2-3 weeks in advance and you are encouraged to find a day/time that works regularly to help ensure continuity of care. Leave such messages at 425-224-5775 more than 24 hours in advance of your session time. Please notice and use the notification light in the waiting room by the tall plant to let me know you have arrived.

_____**Termination**: Therapy is intended to be a working relationship that reaches an ending point when the client's goals have been reached. Good communication between the client/family and Dr. Miller will be essential to our success. Upon reaching a final "termination" session, the client is always welcome to resume work with Dr. Miller at any point in the future, though immediate availability in Dr. Miller's schedule cannot be guaranteed. *In the event there is a span of 2 weeks (14 consecutive calendar days) where the client does not meet with Dr. Miller in the office, and the client has not communicated his/her absence (such as with a vacation or hospitalization), the therapeutic relationship will be considered terminated.*
_____**Independent Practice:** While the office space is shared with other practitioners, Dr. Miller is independent and not a partner or co-owner of a Psychotherapy practice.

_____ **Missed appointments and/or late cancellations less than 24 hours prior to session start time for reasons other than the most serious unforeseen circumstances will be charged the full session rate to you, not your insurance**. Sign up for free reminders at bradymillerphd.com under "reminders" tab. If the client awakens sick on the day of session, please call by 9:00am to cancel the appointment to avoid a missed session charge.

_____**Fees**: The client (or the legal guardian who has signed the *agreement to pay for professional services*) is fully responsible for payment for each session. Payment is due at the time services are rendered, and valuable therapy time will be preserved if checks are completed prior to the beginning of your session. Checks made out to "Brady Miller Psychology" are the preferred payment method and credit cards are accepted. If you are

experiencing difficulty paying your bill, please bring this to Dr. Miller's attention immediately and we will agree to a written payment plan. Any balances older than 60 days without a written payment plan in place are subject to a 1.5% late fee per month. If your balance remains unpaid beyond 90 days and Dr. Miller does not have a mutually-agreed upon and signed payment plan in his possession, by signing this document, you authorize Dr. Miller to turn over the full unpaid balance and relevant contact information to a small claims court and/or a debt collections agency.

_____**Insurance**: You are responsible for understanding your benefits as they relate to my psychological services. *Please note, I am in-network with Premera and SOME Blue Card Networks Only*. Dr. Miller is *out of network with Regence*. I am not pursuing further contracts with insurance networks. I am registered in the National Provider Identifier database. You are responsible for determining whether 1) sessions are covered by your insurance, 2) you understand your insurance policy regarding coverage of sessions and 3) you receive specific authorization (if required) from your insurance provider for sessions. My services are non-emergency services. If you are unsure about your benefits, you are responsible for determining the extent of your benefits coverage of my outpatient mental health services and you remain ultimately responsible for payment for services, though insurance may make payment on your behalf. Dr. Miller's insurance network participation status is subject to change, and you will be notified as early as possible in this event.

_____**Confidentiality:** The laws of the state of Washington require that most issues discussed with a therapist remain strictly confidential (between the client and Dr. Miller). There are some important exceptions to this, however. Laws specifically require the release of confidential information and consultation with proper authorities when a therapist has reasonable suspicion that a child or dependent adult has been physically, emotionally, or sexually abused. Additionally, Dr. Miller is required to release confidential information and consult in situations where he believes the client or someone else poses a physical threat to him/herself or another, or in some cases where the court may order records to be released. In these instances, the release of confidential information and consultation with authorities does not require the consent of the client or guardian.

In situations where Dr. Miller deems appropriate to consult with other professionals, Dr. Miller may consult by sharing the minimum necessary information needed for the professional to understand the client's psychological situation. No identifying information will be shared, and some information may be changed or omitted.

Laws allow you to waive the privilege of confidentiality by signing a "Release of Confidential Information" form. This form identifies a specific person or agency and signing the form allows Dr. Miller to release, obtain, or exchange information with the person or agency specified in the interest of the client's welfare. Because of issues of confidentiality, Dr. Miller will not consent to appear in court proceedings or depositions for any reason.

Dr. Miller has a billing specialist who submits claims and signing this document authorizes Dr. Miller to release minimum necessary information to his billing specialist for the purpose of submitting claims and sending statements.

A recent Washington State ruling now requires the reporting of HIV-Positive/AIDS diagnoses to specific authorities by medical professionals, including Dr. Miller as a Psychologist.

It is my policy to destroy records 7 years after the last date of service, or 3 years after a minor client reaches the age of majority, whichever is later. Until such time, your records will be safely stored in a secure manner in paper form.

If I must discontinue our psychotherapeutic relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

Please check only ONE of the following:

_____Dr. Miller is authorized to contact the client's primary care physician whose name and address are shown below to discuss the treatment I am receiving while under Dr. Miller's care and to obtain information concerning my medical diagnosis and treatment.

_____ I do NOT authorize Dr. Miller to contact my primary care physician with regard to the treatment the client is receiving while under Dr. Miller's care or to obtain information concerning the client's medical diagnosis and treatment. I am providing you with the name and address of my primary care physician only for your records.

Please write the name, address, and phone number of the client's primary care physician below:

_____ _____

Name Phone

_____

Address

_____ _____

Signature Date

_____**Guarantees & Promises**: When you request my services for yourself or for a dependent, be assured that I will do my best to perform all services in a professionally competent manner. My education at Fuller Seminary Graduate School of Psychology (M.A. Psychology, M.A. Christian Leadership, & Ph.D. in Clinical Psychology) provided comprehensive training in a variety of therapy approaches including cognitive-behavioral and psychodynamic therapies. Additionally, my training included comprehensive consideration of developmental, disability, religion & spirituality, ethnic, and socioeconomic status issues to address the needs of clients. I conducted my internship at a Community Mental Health agency in the Los Angeles area, conducting therapy and psychological testing primarily with defiant children, adolescents, and families.

I received training in treatment of Obsessive-Compulsive Disorder through the International OCD Foundation's training institute. I am able to help clients identify OCD, understand habituation, develop a fear hierarchy, and understand and practice exposure and response prevention to reduce OCD symptoms.

I have currently accumulated 24 hours of training specifically in the Complex Integration of Multiple Brain Systems (CIMBS). This therapy integrates current research regarding ways in which processing the client's present experience can promote healthy changes in the brain and override anxious, depressive, and traumatic thought, behavioral, and emotional patterns.

The client and I will work together to determine the best therapeutic approach to achieve the stated goals of therapy. I encourage the client/family to initiate discussions about the course of therapy at any time. You have the right at any time to stop treatment or request a transfer to another professional. In the event you wish to discontinue therapy for any reason, it is requested (but not required) that you allow us as much time as possible to process this change. You have a right to request a review of your records, or to request to add to them or correct them. You also have a right to a copy of your records. There are no guarantees that the process or results of therapy will match all of your expectations. I promise no specific outcome from treatment, and in fact, treatment sometimes is confusing and/or emotionally painful. Effective treatment depends on the client's openness, willingness to collaborate, and commitment to change.

_____**Psychotherapeutic Relationship** Upon beginning a psychotherapeutic relationship with me, I am limited to interactions within the office and limited outside interactions (scheduling, brief check-ins). As your (or your child's) psychologist, I cannot now or ever develop social, romantic, or business relationships (other than psychotherapy) with clients and/or their family members. Also, I cannot treat someone in therapy who is already a friend. I will not engage, seek out, reply to, or "connect" with the client or client's family members on any social media now or in the future. Clear delineation of boundaries is essential to psychotherapy success.

_____**Ethics & Professional Standards**: As a Psychologist licensed by the State of Washington, I strive to uphold the highest standards of my profession. The client, family, or Dr. Miller may initiate discussions on ethical or professional matters at any time. If you are not satisfied with any area of our work, please raise your concerns with me directly at once. I will make every effort to work with you to resolve any concerns that arise. If you feel that I have treated you unfairly or have broken a professional rule, please tell me. You may also contact the Washington State Department of Health (360-236-4700) and Washington State Psychological Association (206-547-4220) are available for questions.

_____**Phone Calls**: I am available to return calls Monday through Friday. Calls placed during the weekend or days I am unavailable will be returned the next business day. I do not conduct email or text messaging as part of my practice. **Please ensure that your voicemail box is not full as this will impede my ability to leave a message for you. Thanks!**

_____**Emergency Calls**: If you experience a life threatening emergency, please call 911 immediately or proceed to your nearest emergency medical center. If you experience a behavioral emergency, please contact the crisis hotline at 866-284-3743.

Our agreement

I, the client (or client's parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during treatment, I have questions about any of the subjects discussed in this brochure, I can talk with you about them, and you will do your best to answer them. I understand that after therapy begins, I have the right to withdraw my consent for therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by Dr. Brady Miller about the results of treatment, the effectiveness of procedures used by Dr. Miller or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this brochure. I hereby agree to enter (or to have the client enter) into therapy with Dr. Brady Miller and to cooperate fully and to the best of my ability as shown by my signature here.

I authorize Dr. Brady Miller, Ph.D. to provide psychological services to [client] _____. This authorization constitutes informed consent without exception. I have read and understand the office policy and have received a copy for myself.

_____

Printed name of Client or Legal Guardian

_____	_____	_____
Signature of Client or Legal Guardian	Date	Brady M. Miller, Ph.D., Psychologist # PY 60200533

Brady Miller Psychology, PLLC

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks, e.g.,

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. *This means that email exchanges and text messages with my office should be limited to administrative matters*. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical

information by email or text and strongly request that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency. In an emergency, please call 911.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24-48 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent Form still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If

you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (425-224-5775).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. *Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.*

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.
Your signature below indicates agreement with its terms and conditions.

_____	_____
Client (If age 13+)	Date
_____	_____
Parent or Guardian of Client age 12 or younger	Date
_____	_____
Psychologist	Date