Kathryn B. Miller, PhD

Licensed Psychologist

Treatment Consent Form

- ☐ I have received and understand the Treatment Guidelines. Any questions I had were answered to my satisfaction.
- ☐ I have received and understand the policies that protect my health information.
- ☐ I understand the 24-hour cancellation policy and the missed appointment policy and accept responsibility for payment.
- ☐ I understand that if I have not scheduled an appointment or contacted Dr. Miller in over 1 month, I am no longer considered a current client.
- ☐ I understand that Dr. Miller uses a billing service, Paragon Billing (952) 835-3938, to submit insurance claims yet it is my responsibility to fully understand my coverage. Dr. Miller does not have the authority to waive co-pays or deductibles.
- ☐ I have received and understand the risks associated with communication via e-mail, text messaging and voicemail. By checking this box, I DO consent to communication via these methods.

____

Client Signature Date

Parent's Consent to Treatment of Minor

I agree to the above bullet points and give permission for my child:____
DOB ___________________________________ to receive mental health treatment from Kathryn Miller, Ph.D., L.P.

____

Parent/Guardian Signature Date

5101 Olson Memorial Hwy, Suite 4004, Golden Valley, MN 55422 T: 763.595.7294 ext. 114 F: 763.595.7293