Megan W. Broadhead
COUNSELING & CARE

WWW.MEGANBROADHEAD.COM
MEGAN@MEGANBROADHEAD.COM
404.236.9730

LIVING FULLY PSYCHOTHERAPY & CONSULTING
1459 OXFORD ROAD NE STE 301
ATLANTA, GA 30307

LAPC - MDIV - MS

**INSURANCE REIMBURSEMENT**

Most health insurance policies provide some coverage for mental health treatment. A "statement" (receipt, superbill, claim form) can be given to a client at the time of service rendered or on a recurring monthly schedule. A client can send these "statements" to his/her insurance company for "out-of-network" reimbursement. Insurance companies *do not* provide reimbursement for canceled or missed sessions. MBCC will work with the client to ensure that the insurance company has all of the information needed to process the claim. Please remember that clients (not insurance companies) are responsible for full payment of service fees. By signing this form, the client provides consent to release all information necessary to process insurance claims, as requested by the respective insurance company (further explanation of this is included in MBCC's consent form as well as in the GA Notice Form).

_____ _____

CLIENT NAME CLIENT SIGNATURE / DATE

**CREDIT CARD AUTHORIZATION**

I hereby authorize MBCC to charge my credit card as follows:

Card type (circle) MC Visa Discover AMEX

Name on Card_____ CC number_____

Exp. date_____ CV code (security code) _____

Address on file for card_____

City_____ State_____ Zip_____

I have read, understand and agree to the above fee payment and credit card policy for services provided by MBCC.

_____ _____

CLIENT NAME CLIENT SIGNATURE / DATE

*(The information requested in this form will be kept confidential.)*

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## BILLING, FEES, & PAYMENT INFORMATION

The standard fee for counseling and psychotherapy service is **$135.**

I reserve a few openings in my practice for clients who require the financial support of a lower rate. *If you think you may qualify, please inquire about this option.*

### BILLING, PAYMENTS AND CANCELATION POLICY

Please read and initial here ____ to indicate that you have read and agree with each policy listed below.

1. Payment is due at the time of service. MBCC accepts payment in the following ways:
    a. Cash, exact change only.
    b. Checks payable to Megan Broadhead Counseling & Care (or MBCC) can be written for services rendered at the time of session. There is a $25 fee for returned checks.
    c. Credit card (Mastercard, Visa, American Express) can be used in two ways for services rendered at the time of session:
        i. Authorized credit card on file can automatically be charged at the time of service.
        ii. Client may present a credit card of their choice at the time of service.
2. MBCC has a 24-hour cancelation policy for all initial intake, consultation, and therapy sessions (individual, couples, family, and groups). Components of this policy include:
    a. Clients are expected to notify Megan of a cancelation via phone or email at least 24 hours prior to their scheduled appointment. Please note that this means 1 full business day before a scheduled appointment. For instance, if clients need to cancel a Monday appointment, they are expected to call or email Megan on the previous Friday to avoid being charged. Should clients call to cancel less than 24 hours in advance, their credit card will be charged for that missed session.
    b. If clients miss an appointment without notifying their assigned therapist, their credit card will be charged for that missed session.
3. MBCC requires that clients provide current and active credit card information. This information is kept in each client's file and the account is charged in the event of the following:
    a. A missed appointment or late cancelation (as noted above).
    b. Returned check fees
4. Sessions begin at the designated time and end approximately 50 minutes later. If clients are tardy to session, an extension of time may not be given.
5. For clients 18 or older a written release of information must be given before any clinical information is shared with the party responsible for remuneration of services rendered (i.e., parents or caregiver).
6. If a client's credit card is not up to date or has been canceled and the account has not been paid for more than 60 days without any attempt for payment arrangements, legal means may be used to secure payment (i.e., collection agencies or small claims courts). Information disclosed during such proceedings include: Clients' name(s), the nature of services provided, and the amount due. If such legal action is necessary, the associated costs will be included in the claim.

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***Please check any relevant concerns.***

## THOUGHTS/FEELINGS/ MOOD

Anger/ frustration/ hostility
Anxiety, nervousness
Attention, concentration, distractibility
Confusion
Depression
Disliking others
Emptiness
Euphoria
Excessive worry
Failure
Fatigue
Fear
Grieving (death, loss, divorce, etc.)
Guilt
Hearing things other people don't
Homicidal thoughts
Intrusive thoughts
Judgment problems
Memory difficulties
Negative thoughts
Obsessive thoughts
Oversensitivity to criticism
Oversensitivity to rejection
Panic attacks
Perfectionism
Sadness
Seeing things other people don't
Self-centeredness
Self-esteem
Shyness
Spiritual, religious, or moral issues
Stress
Sudden mood changes
Suicidal Thoughts
Suspiciousness
Temper problems
Thoughts of hurting self or others

## BEHAVIOR

Aggression, Violence
Alcohol Use
Argumentative
Avoidant
Compulsive behavior/ rituals
Controlling
Decreased / lack of sexual interest
Dependency
Destruction of property
Drug use- prescription, over-the-counter, street
Eating Problems
Financial problems, debt
Gambling
Hyperactivity
Internet problems
Irresponsibility
Isolation
Legal problems
Letting others take advantage of you
Lying
Not able to relax
Pornography
Preoccupation with sex
Procrastination
Purging
Self - destruction/ sabotaging
Self-neglect
Sexual dysfunction
Smoking
Stealing
Threats
Weight, gain/ loss
Withdrawal from others
Loss of interest in what I used to like
Sleep difficulty
Loss of appetite
Overeating

## FAMILY & RELATIONSHIPS

Affair
Childhood issues (your childhood)
Divorce
Friendships
Housework/ chores
Interpersonal conflicts
Parenting
Problems with child(ren)
Problems with spouse/ partner
Separation

## ABUSE

Abuse of alcohol
Abuse of drugs
Emotional abuse by another
Emotional abuse of another
Financial abuse
Neglect
Physical abuse by another
Physical abuse of another
Sexual abuse by another
Sexual abuse of another
Verbal abuse

## WORK & SCHOOL

Absenteeism
Career concerns, goals, choices
Difficulty with coworkers
Difficulty with supervisory
Performance
Tardiness
Procrastination
School problems

## OTHER CONCERNS

_____
_____
_____
_____
_____

I have no problems or concerns bringing me here.

*(The information requested in this form will be kept confidential.)*

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1. Please describe the emotional atmosphere in your childhood home (e.g. displays of affection, parent's relationship, conflict, etc.)
   _____
   _____

2. Is there a history of alcohol and/or drug abuse in your family of origin? _____Yes _____No
   If yes, please describe:
   _____

3. Is there a history of emotional problems and/or treatment in your family of origin? _____Yes _____No
   If yes, please describe:
   _____

**V. COUNSELING CONCERNS**

What challenges are you experiencing that led to seeking counseling?

_____

_____

_____

At this point, what would you like to see happen as a result of counseling?

_____

_____

_____

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Alcohol: _____ Marijuana: _____

Cocaine, Crack:_____ LSD: _____

Inhalents: _____ Other: _____

3. Have you been concerned or ever felt guilty about your use of drugs/ alcohol? ___YES ___NO
4. Has anyone ever expressed concern about your use of drugs/alcohol? _____YES _____NO

   *If yes, who?* _____
5. Have you ever had a DUI? _____YES _____NO

   *If yes, how many?* _____ *When?* _____
6. Have you ever felt the need to cut down on your use of drugs/ alcohol? _____YES _____NO

**IV. FAMILY OF ORIGIN** (*Family in which you were raised)*

| | **Name** | **Current Age** (Or Age at Death) | **Physical and/or Mental Health Illnesses** *(cause of death if deceased)* | **Relationship** *(excellent, good, fair, poor)* |
|---|---|---|---|---|
| **Mother** | | | | |
| **Father** | | | | |
| **Brothers & Sisters** (list separately) | | | | |
| **Others:** (step parents or siblings, grandparents, etc.) | | | | |

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5. How would you rate your present health? ____ *Excellent* _____ *Good* _____ *Fair* _____ *Poor*

6. Current Medication Dosage Frequency Prescribing MD

7. Psychiatrist's Name: _____ Psychiatrist's Phone: _____

8. Have you ever had counseling or psychotherapy in the past? _____YES _____NO
   If yes, when? _____ With whom? _____
   _____ _____

(*FOR WOMEN ONLY)*

9. Do you have any notable menstrual experiences (i.e. regarding regularity, pain, emotional experiences)?
   _____

10. If your menopause has started, at what age did it start? What signs or symptoms have you had?
    _____

11. Anything else about your health history?
    _____

**III. CHEMICAL USE**

1. Have you or any other family member received help for drug or alcohol dependency?
   _____ YES ____NO If yes, when? _____
   Where? _____

2. Check which of the following you use, and note the amount and frequency of each:

Caffeine: _____- Tobacco: _____
Coffee Sodas Other drinks Pills

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# CLIENT INTAKE INFORMATION FORM

Today's Date: _____

## I. GENERAL INFORMATION *(please print)*

Name: Last: _____ First: _____ MI:____

Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY *(if different than above)*

Name: Last: _____ First: _____ MI:____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Phone: _____

Do you grant Megan permission to contact you via the email address you listed?

_____YES _____ NO

*(Megan respects your email privacy and will not share, transfer, sell, or rent your information)*

Date of birth : _____/ _____ / _____

Sex: _____ Male _____ Female _____ Other

Racial/ Ethnic Identity:

*American Indian or Alaska Native* *Asian or Asian Indian* *Black or African- American*

*Hispanic or Latino* *Middle Eastern* *Pacific Islander or Native Hawaiian* *White*

Marital Status:

*Single* *Engaged* *Married/ Partnered* *Separated* *Divorced* *Widowed*

Spouse/ Partner's Name: _____ # of years together: _____

Place of Employment: _____ Job Title: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Religious/ Denominational Preference: _____

Referred by: _____

May I thank the person? _____ Yes _____ No

## II. MEDICAL & PSYCHOLOGICAL HISTORY

1. Physician's Name: _____
2. Physician's Phone: _____
3. Date of last physical: _____
4. List physical illnesses or pain/symptoms:

*(The information requested in this form will be kept confidential.)*