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

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

This form provides Living Fully clinicians with written permission to communicate with other individuals regarding a client's treatment (e.g., previous therapist, current health care providers, parent, financially responsible party).

I, _____ (client), authorize _____ (clinician) to release and/or exchange information about the client's case with the following parties:

NAME RELATION ADDRESS PHONE EMAIL

_____
_____
_____
_____
_____
_____

Information to be Released or Exchanged: (check all that apply and note corresponding contact for each)

_____ Intake and history _____

_____ Treatment Progress Summary _____

_____ Diagnosis and Treatment Plan _____

_____ Discharge Summary _____

_____ Verbal Consultation _____

_____ Billing & Payment (required for financially responsible party if billing through a third party)_____

_____ Other (specify)_____; _____

_____ All of the Above _____

***Living Fully charges $1.00 per page for the release of written records.*

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

Patient Name: _____ Date: _____

Parent Signature if under 18 _____

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

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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. Living Fully 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 Living Fully's consent form as well as in the GA Notice Form).

_____ _____

RESPONSIBLE PARTY NAME SIGNATURE / DATE

CREDIT CARD AUTHORIZATION

I hereby authorize Living Fully Psychotherapy & Consulting, LLC 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 Living Fully Psychotherapy & Consulting, LLC.

_____ _____

RESPONSIBLE PARTY NAME SIGNATURE / DATE

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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. Living Fully accepts payment in the following ways:
    a. Cash, exact change only.
    b. Checks payable to Living Fully Psychotherapy & Consulting, LLC (or Living Fully) 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. Living Fully 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. Living Fully 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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IV. COUNSELING CONCERNS

Circle the symptoms your child displays & list the # of times per week symptom is displayed:

Anger	Anxiety	Bed wetting	Acts out sexually
Conduct problems	Controlling	Day defecation	Has unusual sexual knowledge
Day Wedding	Defiance	Depression	Homicidal thoughts or actions
Disassociates	Drug or Alcohol use	Hyperactivity	Masturbates excessively
Hyper vigilance	Impaired conscience	Isolation	Lack of empathy
Lack of motivation	Lethargy	Low impulse control	Plays out violent themes
Low self-esteem	Lying	Nightmares	Plays out sexual themes
Obsesses	Over/Under eating	Phobias	Peer problems
Phobias	Running Away	Shyness	Sleeplessness
Stealing	Tantrums	Somatic symptoms: Headaches/ stomachaches, etc	
Increase/ Decrease in Appetite			

Other: _____

What challenges is your child experiencing that led you to seek counseling?

_____

_____

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

_____

_____

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3. Does (Parent/ Caretaker #1) work outside of the home? ___ Y, ___ N Occupation:_____Hrs:_____

   Highest level of education: _____

4. Does (Parent/Caretaker #2) work outside of the home? ___ Y, ___ N Occupation:_____Hrs:_____

   Highest level of education: _____

5. If separated and/or divorced, what is your custody arrangement?

   _____

   _____

6. Does either parent/ custodian have legal issues? If so, please describe.

   _____

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

   _____

   _____

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

   _____

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

   _____

10. Has child witnessed domestic violence? ____ Y, ____ N
    If yes, please specify

    _____

11. Does your family have any specific spiritual beliefs, religious involvement, etc.? Please specify.

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III. **FAMILY OF ORIGIN** (*Family in which child has been raised)*

	Name	**Current Age** (Or Age at Death)	**Physical and/or Mental Health Illnesses** *(cause of death if deceased)*	**Relationship** *(excellent, good, fair, poor)*
Parent #1				
Parent #2				
Brothers & Sisters (list separately)				
Others: (step parents or siblings, grandparents, etc.)				

1. Custodial Adults (if not biological parents)
   Date became caretaker: _____

   _____ _____

2. What are 3 adjectives that describe:

   Parent/ Caretaker (1) _____

   Parent/ Caretaker (2) _____

   Child: _____

   Parental Relationship: _____

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Specify amount and frequency:

_____

8. In the first 2 years, did the child experience:
   ____ *Separation from mother,* ____ *Out of home care,* ____ *Disruption in bonding,* ____ *Depression of mother,* ____ *Abuse,* ____ *Neglect,* ____ *Chronic pain,* ____ *Chronic illness,* ____ *Parental Stress*

   If yes, please specify:

   _____

   _____

9. Reached developmental milestones: ____ On time, ____ Early, ____ Late

10. List any current physical illnesses or pain/symptoms:

    _____

    _____

11. How would you rate your child's present health? ____ *Excellent* _____ *Good* _____ *Fair* _____ *Poor*

Current Medication	Dosage	Frequency	Prescribing MD

Psychiatrist's Name: _____ Psychiatrist's Phone: _____

Has your child ever had counseling or psychotherapy in the past? _____YES _____NO

If yes, when? _____ With whom? _____

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Does your child have a learning or physical disability? ___YES , ___ NO, ___ MAYBE
Please specify:

Does your child have a mental health diagnosis? ___YES , ___ NO, ___ MAYBE
Please specify:

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. During pregnancy, did mother use:
   ____ Cigarettes, _____ Alcohol, _____ Drugs, _____ Experience extreme stress
   a. Please specify frequency, amounts, and duration:

_____

_____

5. List any birth complications (Ex: Premature, jaundice, C-section, etc.)

_____

_____

6. List any medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)

_____

_____

7. Does child use: ____ Cigarettes, _____ Alcohol, _____ Drugs

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CHILD 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: _____

Date of birth : _____/ _____ / _____

Sex: _____ Male _____ Female

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

_____YES _____ NO

Are you interested in receiving Megan's monthly email newsletter?

_____YES _____ NO

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

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*

School: _____ Grade: _____

How does your child do in school *academically*?

How does your child do in school *behaviorally?*

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