Jeremy H. Broussard, PhD, LPC
Children, Adolescents, Adults, & Families

Practice Address #1
404 Pere Megret Street
Abbeville, LA 70510
(225) 573-5140

Practice Address #2
321 Travis St.
Lafayette, LA 70503
(225) 573-5140

Today's Date: _____

Client's Name: _____ _____ _____
(Last Name) (First Name) (Maiden, if applicable)

Name of Responsible Party (Parent)_____

Mailing Address: _____

Physical Address: _____

Email Address: _____
***Required*: Counselor may email self-help documents to you between sessions.

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Daytime Phone: _____ Cell Phone:_____

****Please notify our office ASAP if any of the above numbers change!*

Date of Birth: _____/_____/_____ Age: _____ Social Security Number (Parent): _____(*Req.*)

Gender: ☐ Male ☐ Female ☐ Other_____ **Social Security Number (Child): _____**(*Req.*)

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other: _____

Marital Status: ☐ Single ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Type of Counseling: ☐ Individual ☐ Couple ☐ Parent and Child ☐ Family

Referred by: _____

Parental Reminder: If services are for a minor, I understand that my signature below indicates that: (a) I am the domiciliary parent, (b) I will provide court documents indicating domiciliary rights prior to my child's appointment, and (c) give consent for Jeremy H. Broussard, PhD, LPC to contact the non-custodial parent, if needed, for treatment recommendations.

☐ No legal documents regarding custody exist at this time _____ Initials

My signature indicates that all information provided is accurate and true.

Signature of Responsible Party: _____ Date: _____

Who does this client live with?

Name	Age	Nature of Relationship	Name of school he/she attends
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Briefly describe the reason(s) for seeking counseling at this time:

_____
_____
_____
_____

Please place a check besides the following feeling(s) and behavior(s) that describe the client:

- ☐ Academic problems
- ☐ Addictive behavior
- ☐ Aggressiveness
- ☐ Anger
- ☐ Anxiety
- ☐ Compulsive behaviors
- ☐ Crying
- ☐ Cutting
- ☐ Depression
- ☐ Domestic Violence
- ☐ Difficulty concentrating
- ☐ Divorce Adjustment
- ☐ Familial changes
- ☐ Fatigue/loss of energy
- ☐ Fears/Phobias
- ☐ Financial problems
- ☐ Grief/Loss
- ☐ Guilt
- ☐ Helplessness
- ☐ Hopelessness
- ☐ Impulsive behaviors
- ☐ Indecisiveness
- ☐ Irritability
- ☐ Job stress
- ☐ Loneliness
- ☐ Low motivation
- ☐ Lying
- ☐ Mood swings
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Panicky
- ☐ Relationship problems
- ☐ Retirement adjustment
- ☐ Sexual Abuse
- ☐ Sexual problems
- ☐ Social problems
- ☐ Social withdraw
- ☐ Stress
- ☐ Substance abuse (drugs or alcohol)
- ☐ Suicidal attempts
- ☐ Suicidal thoughts
- ☐ Sleep problems
- ☐ Trauma
- ☐ Video games (excessive)
- ☐ Weight loss
- ☐ Weight gain
- ☐ Other:_____

Is there a <u>family history</u> of alcohol and/or drug use? ☐ Yes ☐ No If yes, by whom? _____

Does <u>the client</u> have a history of alcohol and/or drug use? ☐ Yes ☐ No

Is the client on any medication? ☐ Yes ☐ No

Name of medication:	Prescribed by:	Reason for:	Dosage:	Length of time taken
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Counseling Service Policies:

Arrival Time: As a courtesy, please arrive on time. All appointments are scheduled on the hour and last 50 minutes. If you are running late, please contact our office to inform us of the delay If you are 20 minutes late, it may be in your best interest to consider rescheduling. If you do reschedule, you will be responsible for the late rescheduling fee.

Cancellations: Clients will be charged a $50 fee in the event of:

(a) Appointments cancelled LESS than 24 hours in advance
(b) NOT showing up for a scheduled appointment

Payments for missed appointments MUST be paid in full before an appointment can be rescheduled. Cancellations can be made by contacting our office at (225) 573-5140.

Children: Children are not to be left alone or unattended in the waiting room. When parents are in a counseling session, I require them to arrange for another responsible adult to care for their minor children. When children are in a counseling session, I require that a parent or another responsible adult remain in the waiting room until the session ends.

Communication:

a) Text messages: Are responded to within 24hrs.
b) Email: Are responded to within 72hrs.
c) Voice Mail: Are responded to within 24hrs. Please do not leave multiple voice messages as this may delay our response time.

Credit Cards: All clients are required to have a credit or debit card on file. No exceptions allowed.

Emergencies: During and after office hours, clients with emergency medical or mental health situations are directed to call 911 or to present to their local emergency room for intensive crisis assessment.

Insurance: As a courtesy to your, Progressive Medical Services Inc will bill your insurance carrier. However, in the event that your insurance does not pay for services rendered, you will be responsible for paying the entire contracted rate designated by your insurance provider. If payment is denied by your insurance company, you will receive a letter from Progressive Medical Services Inc. Remember that all checks and other forms of payment are made out to Jeremy H. Broussard, PhD, LPC.

Rescheduling: When receiving the appointment reminder text, if a client decides to reschedule (R) then it is your responsibility to contact our office to schedule a follow-up appointment.

I have read and understand this policy statement.

Client's name_____

Printed Name of Responsible Party: _____

Signature of Responsible Party: _____

□ Client request a copy of the Counseling Service Policies □ A copy was provided to the client

Insurance, Medicaid, & EAP

Client Name: _____ Client D.O.B.: _____

Name of Insured: _____ Insured D.O.B.: _____

Insured's Address: _____ Effective Date of Policy: _____

_____

_____

Insured's Phone #: _____

Insured's Employer: _____

Insured's Social Security Number: _____

Insurance Company's Information

Name: _____

Address: _____ Account/ID #: _____

_____ Group #:_____

Insurance Company's Phone Number: _____

Authorization to release information to insurance carrier

I authorize Jeremy H. Broussard, PhD, LPC to release any information necessary to the above named insurance carrier and benefits be made payable to Jeremy H. Broussard, PhD, LPC in my behalf.

Client's Signature: _____ Date: _____

Important Points To Remember:

- You are responsible for knowing (a) whether your insurance will cover mental/behavioral health counseling and (b) if authorization is required.
- Not all insurances plans cover counseling. Those that do may place a limit on the number of sessions per year.
- If your insurance plan does not cover these services, you will be responsible for the fees outlined in the Declaration of Practice.
- You will have *approximately* 90 days to pay any balance on your account.
- After 90 days, if the balance is not paid, your account will be turned over to a collection agency.
- Missed appointments are charged a $50.00 fee.
- A missed appointment must be paid before another appointment can be scheduled.