

Dr. Vanessa A. Schaeffer
973 Enota Ave., N.E., Gainesville, GA 30501
(770) 531.9226 Fax (770) 531.5531

PATIENT INFORMATION (Must be completed before services can be rendered)

NAME _____
 First Middle Last

ADDRESS _____
 Street City State Zip

PHONE Work (_____) _____ Home(_____) _____ Cell(_____) _____

SOCIAL SECURITY _____ SEX Male Female

MARITAL STATUS _____ DATE OF BIRTH _____

EMPLOYER _____

EMPLOYER ADDRESS _____

RESPONSIBLE PARTY/SPOUSE/PARENT INFORMATION

NAME _____
 First Middle Last

ADDRESS _____
 Street City State Zip

PHONE Work(_____) _____ Home (_____) _____ Cell (_____) _____

PRIMARY INSURANCE _____

NAME OF CARRIER _____

ADDRESS _____ PHONE _____

NAME OF INSURED _____ GROUP # _____

ID# _____ DATE OF BIRTH OF INSURED _____

SOCIAL SECURITY OF INSURED _____

I authorize the release of any medical/psychological information necessary to process my insurance claims/ I authorize and request payment of medical benefits directly to Vanessa A. Schaeffer, PsyD. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for any and all charges not covered by this assignment.

Signature

Date

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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

- May I have your permission to thank this person for the referral?
 Yes No
- If referred by another clinician, would you like for us to communicate with one another?
 Yes No

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

What are your goals for therapy? _____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

**The following information on this form will help guide your treatment.
Please try to fill out as much as you are comfortable disclosing.**

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): _____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

Have you talked with a psychiatrist, psychologist, or other mental health professional? YES NO
 (Please list approximate dates and reasons): _____

Height _____ Weight (if applicable) _____ Age _____ Gender _____

Sexual & Gender Identity: Heterosexual Lesbian Gay Bisexual Transgender
 Asexual In Question Other

Racial/Ethnic Identity:

African/African-American/Black Latino/Latino-American Bi-Racial/Multi-Racial
 American Indian/Alaska Native Middle Eastern/Middle Eastern-American
 Asian/Asian-American/Asian Pacific Islander White/European-American Not listed

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? _____ How Long? _____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships _____

Do you have Children? _____ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

Please briefly describe any history of abuse, neglect and/or trauma: _____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: _____

Is spirituality important in your life and if so please explain: _____

Briefly describe your diet and exercise patterns: _____

EDUCATION & CAREER

High School/GED _____ College Degree _____ Graduate Degree(or Higher) _____ Vocational Degree _____

What is your current employment? _____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant? _____

What do you think are your strengths? _____

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				“Nervous Breakdown”			

Any additional information you would like to include:

Type text here

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

Information regarding my educational background and experience as a therapist is an ethical requirement of my profession and is available on the website at www.gainesvillepsychologist.com. If you have any questions, please feel free to ask.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever ways seem to produce maximum benefit.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the

Please initial that you have read this page _____

disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Structure and Cost of Sessions

I agree to provide psychotherapy for the fee of \$185 per 75 minute Initial Evaluation and \$165 per 45-50 minute session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at \$2.50 per minute. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard or Discover are acceptable for payment, and I will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$50 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

One of my responsibilities as a therapist is to not accept more active patients to my care than I can provide follow-up appointments for. With a full roll of active patients, I am unable to accept new patients until someone leaves my care. When an active/current patient no longer needs or wants my services, I will close/make inactive his or her file. Therapy hours previously reserved for him/her will then be made available to a new patient. If you cancel or no show and appointment and wish to remain an active patient in my practice, please call or contact me within two weeks of the missed appointment to reschedule. If I do not hear from you within two weeks of a missed appointment, I will close your file and accept a new patient into my practice from my waiting list.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions. Please be aware that it is my policy that if you miss or late-cancel too many appointments, it will indicate to me that you are not able to make the necessary progress in therapy and I will not be able to schedule further appointments for you.

In Case of an Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, phone calls are returned within 24-48 hours. If you have a mental health emergency, you are encouraged not to wait for a call back, but to do one or more of the following:

- Call Northeast Georgia Medical Center at 770.219.9000.
- Call 911.
- Go to your nearest emergency room.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to

Please initial that you have read this page _____

offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. **However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.**

Facebook, LinkedIn, Instagram, Pinterest, Etc: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Please initial that you have read this page _____

Google, etc.: It is my policy not to search for my patients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: I may post psychology news on Twitter or write an entry on a blog. If you have an interest in following either of these, please let me know so that we may discuss any potential implications to our therapeutic relationship. Once again, maintaining your confidentiality is a priority. I would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to my content.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Our Agreement to Enter into a Therapeutic Relationship

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you.

Client Name (Please Print)

Date

Client Signature

If Applicable:

Parent's or Legal Guardian's Name (Please Print)

Date

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Therapist's Signature

Date

Please initial that you have read this page _____

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PAYMENT POLICY/CREDIT CARD AUTHORIZATION FORM

FEES: Patients seen by Vanessa A. Schaeffer, Psy.D. will pay the agreed upon amount for services provided at the time of service. Cash, checks and credit cards will be accepted as forms of payment. Please note that there is a \$50 fee for returned checks. **You are responsible for payment at time service is provided.** All patients are required to provide a credit card number to keep on file in case of missed appointments or late cancellations. **If you “no show” your appointment without 24-hour or more notice, a \$75 fee will be charged to your card on file.** Please note that insurance companies do not reimburse for missed appointments.

I hereby authorize Vanessa A. Schaeffer, Psy.D. to charge my credit card as follows:

Card Type: MC Visa Discover

Name on Card: _____

Card Number: _____

Expiration Date ____/____/ ____

CVC code (on back of card) _____

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 Vanessa A. Schaeffer, Psy.D.

Signature

Date

To better clarify the role that I will play as your therapist, please be aware of the following:

I do not get involved in work grievances, lawsuits, custody disputes, disability determinations, or other legal or administrative proceedings, including work excuses and requests for change in job conditions. If you require a medical advocate for any of the above reasons, you need to hire one elsewhere; I am here to provide therapy.

Patient Signature

Date

Witness