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

Dr. Vanessa A. Schaeffer, Psy. D.

973 Enota Avenue NE Gainesville, GA 30501

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:** _______________

Employed? ________________ **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:____

Relationship to you: _____________________ *Phone number:* _________________________________

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? ____

____

____

____

____

MEDICAL HISTORY:

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

____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Please attach an additional sheet with additional Medications or more detailed medical history.

Who is your PRIMARY CARE PHYSICIAN? ____

Please provide PCP's address and phone: ____

Have you ever been evaluated for memory issues? ____

Is there a family history of dementia disorders? _____________If yes, who? __________________

Please describe type of diagnosis, age at diagnosis ____

Is there a family history of mental health conditions? ________________If yes, who? ___________

Please describe type of diagnosis, age at diagnosis ____

____

Do you have a history of falling? If yes, how recently? _____________________________________

If yes, how frequently? ____

Have you ever had a head injury? ___________If yes, when? ______________________________

Do you wear eyeglasses? _______________ Date of last eye exam? _________________________

Do you wear hearing aids? _______________ Date of last hearing test? ____________________

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 any of your 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 ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

Please list approximate dates and reasons: ____

Please put a check mark under the response that best describes your ability to do the following tasks:

	Fully Independent	Need Some Assistance	Requires Total Assistance
BATHING			
DRESSING			
TOILETING			

TRANSFERRING:
Move from sitting to standing on own? ____

Move from a chair to bed on own? ____

CONTINENCE (managing bowel and bladder?) ______________________________________

Bowel or bladder accidents? No ____________ Yes ________________ How often? ___________

FEEDING (bring food to mouth, chew and swallow?) ________________________________

HOME MAINTENANCE & HOUSEWORK ____

SHOPPING ____

COOKING ____

COMMUNICATION (using the phone/managing mail) ________________________________

MANAGING MONEY ____

MANAGING TRANSPORTATION (Do you drive?) ___________________________________

Do you arrange other transportation for yourself? ____________________________________

MANAGING MEDICATION ____

MANAGING MEDICAL APPOINTMENTS _____________________________________

DO YOU HAVE ADVANCED DIRECTIVES? ____

DO YOU HAVE A LIVING WILL? ____

IF YES, PLEASE PROVIDE A COPY FOR MY RECORDS. ________________Date received

Height __________ Weight __________ 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:

Are your parents living? ________________If no, indicate their age at death and cause of death:

Mother ____

Father ____

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: 1 2 3 4 5 6 7 (POOR – 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: 1 2 3 4 5 6 7 (POOR – EXCELLENT)

Any past career positions that you feel are relevant?
____
____

What do you think are your strengths?
____
____
____

Please provide any other information you think would be helpful for our work together:
____
____
____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

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"	

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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