ANGELA D. SCHAFFNER
Psychologist. Author. Black Belt.

Schaffner Psychotherapy Services, LLC
Client Information Form

Name: _____
Date: _____
Age/DOB: _____
Address: _____

E-mail: _____ Ok to contact you here? **Y/N**
Cell phone: _____ Ok to call/text you here? **Y/N**
Home phone: _____ Ok to contact you here? **Y/N**

How did you hear about my practice? _____
If referred, may I thank the referral source? Y/N

Who may I contact in the event of a medical or mental health emergency?
_____

What is your racial/ethnic background? _____

What is your relationship status (married, single, separated/divorced, widowed, dating, partnered)? _____

What is your sexual orientation (straight, gay, lesbian, bisexual, queer, other)?
_____

What is your gender identity (male, female, transgender, other)?
_____

Are you a parent? If so, how many/how old? _____

Do you have a religious/spiritual orientation? If so, please describe: _____
_____

Previous Therapy Experience: Yes/No
If yes, place an "X" on this line indicating how helpful it was to you:

Not helpful----------Very helpful

Briefly state the top 3 reasons why you are seeking therapy at this time:
_____
_____
_____

Which emotional coping strategies work best for you? (e.g., distraction, talking to a friend, yoga, journaling, etc.)
_____
_____
_____

Are you currently having any suicidal thoughts? Y/N
Have you ever been suicidal in the past? Y/N
Have you ever attempted suicide? Y/N
Do you know anyone who has died by suicide? Y/N

Do you take any medications? If so, please list type and dosage.
_____
_____

Who is your primary care physician? _____
Date of last physical? _____
Who is your psychiatrist? _____
Date of last visit? _____

Have you ever experienced what you would consider a traumatic event? If so, please describe.
_____
_____
_____

Have you ever had an unwanted sexual experience? If so, please indicate how old you were, your relationship to the person, and whether you ever told anyone about it.
_____
_____
_____

Did any of your primary caregivers have a problem with drugs/alcohol? **Y/N**

Anything else you'd like me to know? _____
_____

Schaffner Psychotherapy Services, LLC
Fees & Payment Form

I authorize **Schaffner Psychotherapy Services, LLC**, to charge my credit/debit card for each scheduled appointment or service. I understand that if I do not cancel or reschedule a set appointment **within 24 hours of the appointment**, my card will be charged in full for the missed appointment. *Missed appointments with less than 24 hours' notice will be charged the full rate even if you reschedule for that same week.*
Fees for my services are as follows:

Intake (first) appointment (45-50 minutes):	$200
Therapy session (45-50 minutes):	$180
No show/late cancellation (<24 hours):	$180
Business consultation/clinical supervision	$125/hour
Clinical consultation/collaborative care	$125/hour (no charge for <10 min)
Services related to legal proceedings	$300/hour

Name: _____

Signature: _____

Date: _____

Card #: _____

Exp. Date: _____

CVV Code: _____

Billing Zip: _____

Office Policies:

1. I reserve the right to raise my fees due to changes in the market (usually $5-10 every 2 years, at the start of each calendar year).
2. Payment is due at the time of service, unless we agree otherwise.
3. A receipt/superbill for each session will be e-mailed to you if you'd like to submit it to your insurance company for out-of-network benefit coverage. Would you like to receive superbills after each session? **Y/N**

Schaffner Psychotherapy Services, LLC

Release of Information Form

This form authorizes Angela Schaffner, Ph.D., to communicate with other individuals regarding your treatment (e.g., family member, another health care provider). This release will be valid until the termination of treatment or until withdrawn in writing by you during the course of treatment.

I, _____, authorize Dr. Angela Schaffner to communicate with the following people regarding my treatment:

Name/Relation	Address	Phone #

This release is valid until the completion of treatment or until withdrawn in writing during the client's treatment. The release includes:

___Diagnosis & Treatment Plan
___Intake & History
___Verbal Consultation
___Progress & Discharge Information
___Billing & Payment
___**All of the above**

Client Name	
Client Signature	
Parent Signature (if client is under 18)	
Date	

Schaffner Psychotherapy Services, LLC
Consent for Treatment Form

Your signature below indicates that:

1. You have read the Schaffner Psychotherapy Services, LLC "Consent Form for Psychological Services" agreement and you agree to its terms.
2. You acknowledge that you have received the HIPAA "Georgia Notice Form."
3. You have read the Schaffner Psychotherapy Services, LLC "Consent for Telemental Health Services" and you agree to its terms.

Printed Name: _____

Signature: _____

Parent Signature (if under 18): _____

Today's Date: _____

Psychologist's Signature: _____