

# CLIENT INFORMATION PACKET

Jennifer D. Vann, MS, LAMFT  
Marietta Counseling for Children & Adults  
2440 Sandy Plains Rd. Building 13 Suite 300  
Marietta, GA 30066

**\*\* Please fill out the paperwork for the person identified as the client.  
If your child is who will be seen, please answer accordingly.**

Today's Date \_\_\_\_\_

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian's Name (if applicable) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

May I send information to this address?  Yes  No

If No, please provide an address where information can be mailed: \_\_\_\_\_

Home Phone Number \_\_\_\_\_ May I contact you at this number?

Yes  No  Disguised

Cell Phone Number \_\_\_\_\_ May I contact you at this number?

Yes  No  Disguised

Work Phone Number \_\_\_\_\_ May I contact you at this number?

Yes  No  Disguised

If there are any further restrictions when calling you, please list them here \_\_\_\_\_

Education Level Completed \_\_\_\_\_ Occupation \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ 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:*** \_\_\_\_\_

Referred by \_\_\_\_\_

Please briefly describe your presenting concern(s): \_\_\_\_\_

---

---

---

---

---

How many sessions do you anticipate to address these concerns?

1-5

6-10

11-20

20+

I don't know

MEDICAL HISTORY

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

---

---

---

Current Medications                      Indication                      Dosage                      Frequency                      Side Effects

*Please include over-the-counter medications and vitamins*

---

---

---

Past Medications                      Date(s)                      Indication                      Dosage                      Side Effects

---

---

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? \_\_\_\_\_

Do you use any illicit drugs?  Yes  No                      If yes, which? \_\_\_\_\_

Do you exercise?  Yes  No                      If yes, how often? \_\_\_\_\_

PSYCHIATRIC HISTORY

Have you ever talked with a mental health professional before today?  Yes  No

If yes: Date(s)                      Type of Treatment                      Reason                      Professional Seen

---

---

---

Would you like me to contact any of your previous providers?  Yes  No

If yes, please provide their contact information \_\_\_\_\_

---

---

FAMILY INFORMATION

Are you currently in a relationship?  Yes  No                      If yes:  Married  Partnered

How long in current relationship? \_\_\_\_\_                      Any previous significant relationships?  Yes  No

Please list all the people that live in your household and your relationship to them:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Please list any family members who do not live in your house, but are important to you:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Where they live \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Where they live \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Where they live \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Where they live \_\_\_\_\_  
Occupation \_\_\_\_\_ Education Completed \_\_\_\_\_

Has anyone in your family, including parents, siblings, grandparents, aunts and uncles ever suffered

from the following:  Depression Who? \_\_\_\_\_

Anxiety Who? \_\_\_\_\_

ADHD Who? \_\_\_\_\_

Bipolar Disorder Who? \_\_\_\_\_

Schizophrenia Who? \_\_\_\_\_

Other Who/What? \_\_\_\_\_

What family situations or issues do you feel are important to my better understanding your current situation? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LEGAL ISSUES

Have the concerns you have today resulted in any legal issues?  Yes  No

If yes, please describe briefly: \_\_\_\_\_

---

Are you currently involved in any lawsuits, custody battles, or other legal battles?  Yes  No

Is therapy part of any court mandated requirement that you are required to complete?  Yes  No

BEHAVIOR CHECKLIST

Please mark if you have had difficulty with any of the following currently or in the past:

*Mental Health Symptoms*

- |                       |                                  |                               |                           |
|-----------------------|----------------------------------|-------------------------------|---------------------------|
| Anxiety               | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Depression            | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Mood Changes          | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Anger/Temper          | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Panic                 | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Fears                 | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Irritability          | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Concentration         | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Loss of Memory        | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Excessive Worry       | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Feeling Manic         | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Trusting Others       | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Drugs                 | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Alcohol               | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Frequent Vomiting     | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Eating Problems       | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Severe Weight Gain    | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Severe Weight Loss    | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Sleeping Too Much     | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Sleeping Too Little   | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Nightmares            | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Head Injury           | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Speaking w/o Thinking | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |
| Completing Tasks      | <input type="checkbox"/> current | <input type="checkbox"/> past | Time of first onset _____ |

Waiting your turn	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Paying Attention	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Easily Distracted	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Hyperactivity	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Making Careless Mistakes	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Fidgeting	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____

*Relationships*

With people in general	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Parents	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Current relationship	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Friends	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Coworkers	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Employer	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Finances	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Legal Problems	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Sexual Problems	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
History of Child Abuse	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
History of Sexual Abuse	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Domestic Violence	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Homicidal Thoughts	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Suicidal Thoughts	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____

*Physical Symptoms*

Increased Stress	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Fainting	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Dizziness	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Diarrhea	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Headaches	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Shortness of Breath	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Chest Pain	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Lump in Throat	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Sweating	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Heart Palpitations	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____

Muscle Tension	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Pain in Joints	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Allergies	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Chills	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____
Hot Flashes	<input type="checkbox"/> current	<input type="checkbox"/> past	Time of first onset _____

Any additional information that you would like to include \_\_\_\_\_

---

---

---

---

## **INFORMED CONSENT**

Jennifer D. Vann, MS, LAMFT  
*Marietta Counseling for Children and Adults, LLC*  
2440 Sandy Plains Rd. Building 13 Suite 300  
Marietta, GA 30066

The following contains important information about the professional services provided by Jennifer D. Vann, MS, LAMFT. This document is designed to inform you about what you can expect from me regarding my understanding of therapy, 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 a part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Should we choose to enter into a therapeutic relationship, please know that it is a collaborative experience and I welcome any questions, comments, or suggestions at any time. By you signing this document we enter into an agreement that allows me, Jennifer D. Vann, MS, LAMFT, to provide therapeutic services to you.

### Background Information

The following is a brief description of my educational background and related therapeutic experience. I received a Bachelor of Science Cum Laude in Sociology from Appalachian State University in 2003 and a Masters of Science in Family Studies, Marriage and Family Therapy from the University of Kentucky in 2006. I have been providing therapeutic services to adults, children, families, adolescents, and groups since 2004. I am licensed in the state of Georgia as an Associate Marriage and Family Therapist and am currently pursuing my certification as a Registered Play Therapist. I worked at the University of Kentucky Family Center where I gained experience working with young children using play, art, and other creative methods. I also spent 7 years in a university setting working with students to achieve academic and social success. Prior to joining MCCA, I worked with an adolescent psychiatrist gaining experience in crisis management and providing therapy to children and adolescents with significant mental health concerns. I am currently contracted with Marietta Counseling for Children and Adults, LLC to provide outpatient mental health services.

### Theoretical Views and Client Participation

I believe that a therapeutic relationship is based on a collaborative partnership between my clients and me. You are unique and your therapy experience and your solutions will be as well. I believe that people are very capable of discovering the solutions that work best for them by experiencing the things and people around them in a new way. In our sessions, I want to create an environment where you will feel safe exploring questions and solutions to the concerns that brought you in. I believe that it is my job as a therapist to ask questions that will help you find your own answers.

### Services Provided

During your first session, I will speak with you about the reasons that you scheduled your first appointment. If you are seeking therapy for your minor child, I require that I meet with the parent(s)/guardian(s) alone for the first session. During this time a decision will be made between client and therapist as to whether or not we are a good fit for treatment or if an outside referral will be made to someone with more expertise in your area of need. I encourage you to interview several therapists to find the best fit for you/your family. Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions while others may take years to complete their process. Please note that when working with children, the therapeutic process typically takes longer and is slower. Children need to feel comfortable with the therapist with whom they are working and processing significant issues require high levels of trust and safety.

If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

### Working with Children

Due to the importance of trust between client and therapist, when the client is a minor child I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If, at any time, I feel like your child is engaging in dangerous behavior I will immediately inform you of the situation, or have your child do so as part of the therapeutic process. I will regularly update you on your child's progress and I encourage you to contact me as frequently as you feel is needed. I will not provide you updates after each session, however if you need to speak with me about your child's behavior please call prior to their weekly session or arrange a time to come in and speak with me. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem. I am sensitive to a parent's needs to be involved in the process and that is why parenting and family sessions are typically a regular occurrence during the treatment process.

### Risks

Given the work required for personal growth and change to occur, therapy may involve some risks. Since therapy involves discussing difficult aspects of life, you may experience uncomfortable feelings or strong reactions. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy. Please ask questions if you have any concerns. There are no guarantees for successful therapy due to the overall complexity of the process and the multiple variables brought into it by each individual.

### Confidentiality

The information you share with me both written (i.e. intake paperwork) and verbally is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. I will not release your information to anyone, including your family and insurance company if you are a legal adult, without *written* consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and therapist/parent for their particular situation. It may be imperative to my therapeutic relationship with a child or adolescent not to reveal the information disclosed to me in session to their parents/guardians. It is important that all parties involved in the therapeutic process are clear on our communication expectations. It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

- 1) When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
- 2) Therapists are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
- 3) When a judge orders that information be disclosed. I can not guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
- 4) When Homeland Security requests information, according to the Patriot Act.

### **Waive right to subpoena**

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by "a licensed...marriage and family therapist... during the psychotherapeutic relationship." If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs. If for any reason I am required to participate in court proceedings my regular hourly fee will be applied from door to door. In addition, I reserve the right to charge for court preparation including case review, report preparation, and legal and ethical review at \$75 per hour.

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

### Clinical Diagnosis for Insurance Purposes

Many clients decide to seek reimbursement for services through their insurance company. While I do not accept any forms of insurance directly, I am willing to provide you a “superbill” with information that will help you seek reimbursement from your insurance company. Please be advised that most insurance companies require a diagnosis in order for reimbursement to occur. Any diagnosis submitted to an insurance company will become a part of you/your child’s permanent medical record.

### Supervision

I am licensed as an Associate Marriage and Family Therapist. The State of Georgia requires all associate therapists to seek out supervision on cases they are involved with. Supervision helps to ensure that you and your family are receiving the best of care and that appropriate measures are being taken to ensure that your needs are being met. I have contracted with a State Board approved supervisor to oversee all of my cases. This supervisor is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or specific identifying information. If you have any questions about this process you are encouraged to ask them at any point during your time in therapy.

### Fees

Clients seen by Jennifer D. Vann, MS, LAMFT agree to pay \$100.00 per 45-50 minute session. Services will be provided by Jennifer D. Vann as contracted through Marietta Counseling for Children and Adults. Any services beyond the standard 45-50 minute session, such as phone consultation exceeding 20 minutes, excessive paperwork, or court appearances/preparation, will incur additional fees as listed above. Jennifer D. Vann, MS, LAMFT reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. As of January 1, 2009 cash, checks and credit cards will be accepted as forms of payment. *If you are using a credit card a processing fee of \$3.00 will be added to your session fee.* I will be happy to provide you with a receipt for payment. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

I also provide a limited number of reduced-fee spaces in my case load. If you feel that you qualify for one of these slots, please inform me at the *beginning* of our first session. Because these slots are limited there may be a waiting list. If there are no slots immediately available I am able to provide you with other low-cost or sliding-scale referrals.

Insurance companies have many rules and requirements specific to certain plans. If you choose to file with your insurance company for reimbursement, it is your responsibility to understand their policies and requirements for reimbursement. I will be glad to provide you with a statement for your insurance company provided you sign a written release of information giving me permission to do so.

### Cancellations

You are expected to attend all scheduled sessions with your therapist. I understand that “life happens” and that unexpected interruptions occur particularly with children and adolescents, but I do expect you to make therapy a priority. If you need to cancel your appointment please call **NO LATER THAN 24 HOURS PRIOR** to your scheduled appointment. You will be charged \$50.00 for appointments cancelled with less than 24 hours notice. MCCA requires all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. If you “no show” or cancel your appointment without 24-hour notification the \$50.00 cancellation charge *plus* the \$3.00 process fee for credit cards will be charged to your card. Please note that insurance companies do not reimburse for missed appointments.

Any files that have no activity for a period of 3 months will be closed.

### Upon my permanent incapacitation or death

In case of any personal emergency when I am unable to contact my clients the clinical staff at MCCA has access to client's first name(s) and contact information only. Your contact information is kept in a secure location on the premises of MCCA and only clinical staff has access to it. Again, this is only your contact information. No other information is available except as noted in the paragraph below.

In case of my death or permanent incapacitation Lynn Louise Wonders, MA, LPC, Director of Services at MCCA has agreed to abide by my confidentiality statement (listed in this informed consent) and will become the sole owner of all case files held in my possession at that time. Any dissemination of information from those files will then be at the discretion and clinical judgment of Ms. Wonders. Upon my permanent incapacitation Ms. Wonders may be contacted at 404-455-5805.

### Emergencies

Jennifer D. Vann, MS, LAMFT does not provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24 hour availability. Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one of more of the following:

- 1) Call Ridgeview Institute at 770.242.4567 or Peachford Hospital at 770.454.5589
- 2) Call 911
- 3) Go to the emergency room of your choice
- 4) Cobb County Mental Health Crisis Line 770.422.0202
- 5) Fulton County Mental Health Crisis Line 404.730.1600

### Ethical Considerations

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Association for Marriage and Family Therapy. I make it a priority to be familiar with the AAMFT Code of Ethics and to structure my practice to follow those guidelines. 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 Georgia Association for Marriage and Family Therapy and the American Association for Marriage and Family Therapy, both which govern my profession.

In order to maintain ethical standards I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

**\*Please sign and return this page\*\***

Consent to Treatment

By signing below you agree that you have read (or have had read to you) all of the above sections of Jennifer D. Vann’s, MS, LAMFT informed consent form and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to pay the disclosed fee for services rendered and to provide 24 hours notice to cancel your appointment.

If Applicable:

\_\_\_\_\_  
Signature (Client/Parent/Guardian)      Date

\_\_\_\_\_  
Minor’s Name

\_\_\_\_\_  
Signature      Date

\_\_\_\_\_  
Signature      Date

\_\_\_\_\_  
Signature      Date

Initial here:

- \_\_\_\_\_ I have read & understand the “Working with Children” section.
- \_\_\_\_\_ I have read & agree to the “Waive Right to Subpoena” section.
- \_\_\_\_\_ I have read & agree to the “No Secrets” policy.
- \_\_\_\_\_ I have read & understand the “Cancelation” section.

**\*\*Please sign and return this page\*\***

## Credit Card Policy

Marietta Counseling for Children & Adults, LLC  
2440 Sandy Plains Rd. Bld. 13, Ste. 300  
Marietta, GA 30066

"I am hereby entering into a contract for Jennifer D. Vann's professional time and services when I set an appointment. I understand that by entering this contract for Jennifer D. Vann's professional time I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Jennifer D. Vann's cancellation policy requires 24 hours advance notice in order to be released from the contract for Jennifer D. Vann's time and services of preparation for my session. I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of \$50. I hereby authorize Marietta Counseling for Children & Adults, LLC to charge my Visa/MC/Discover/ AMEX (please circle) credit card number \_\_\_\_\_ exp. date \_\_\_\_\_ cvcode \_\_\_\_\_ if I indeed fail to observe this cancellation policy and I understand I am paying for preparation services rendered and time contracted for when I set the appointment. "

I have read and understand the above credit card policy for services provided by Jennifer D. Vann, MS, LAMFT through Marietta Counseling for Children & Adults, LLC. Please have all consenting adults sign below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\*\*Please sign and return if there is someone you'd like me to speak with\*\***

**RELEASE OF INFORMATION**

Jennifer D. Vann, MS, LAMFT  
Marietta Counseling for Children and Adults  
2440 Sandy Plains Rd. Building 13 Suite 300  
Marietta, GA 30066

**\* This form must be completed in full in order to be valid\***

Client's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby request and authorize Jennifer D. Vann, MS, LAMFT :

To Release To \_\_\_\_\_ (Must be an individual's name. No Organizations)

Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

To Request From \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

**The following information:**

Psychiatric Evaluation     Social History

Laboratory Reports     Care Plan

Summary of Treatment     Attendance

Clinical Assessment

School Information

Other (please describe)

**For the purpose of:**     Coordination of Treatment     Other \_\_\_\_\_

*Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Jennifer D. Vann, MS, LAMFT disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent understate and/or federal law. Please note that once information has been released to the designated party Jennifer D. Vann, MS, LAMFT nor Marietta Counseling for Children and Adults, LLC are liable for the misuse of information by that party.*

After giving due consideration to the above statement, I authorize Jennifer D. Vann, MS, LAMFT to furnish/receive information, including faxed copies of my Protected Health Information, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Jennifer D. Vann, MS, LAMFT and Marietta Counseling for Children and Adults, LLC from all liability that may arise from the release of the information herein requested.

I understand that this authorization is subject to revocation at any time *in writing* except to the extent that action has been taken in reliance and is only valid for a period of 1 year from the date of my signature unless I specify another date or event here:

\_\_\_\_\_.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

Jennifer D. Vann, MS, LAMFT  
Marietta Counseling for Children and Adults, LLC  
2440 Sandy Plains Rd. Bldg. 13, Suite 300  
Marietta, GA 30066  
770-971-9311

## PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE READ IT CAREFULLY.

*This notice shall go into effect January 1, 2009 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.*

### I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: *treatment, payment, and health care operations.***

***Treatment*** refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

***Payment*** is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

***Health care operations*** are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The ***use*** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care.

***Disclosures*** refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

### II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are

my notes “recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual’s medical record.” “Psychotherapy notes” are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. “Psychotherapy notes” are not the same as your “progress notes” which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your “designated record set” which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your “designated mental health record.”

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

### **III. Business Associates Disclosures**

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as “Business Associates.” I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

### **IV. Uses and Disclosures Not Requiring Consent nor Authorization**

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out “Duty to Warn” Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s)).

I never release any information of any sort for marketing purposes.

### **V. Client’s Rights and My Duties**

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;

- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of non-authorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Associate Marriage and Family Therapist on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

#### **VI. Complaints**

Lynn Louise Wonders, MA, LPC, the clinical director of Marietta Counseling for Children & Adults, LLC is the appointed “Privacy Officer” for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 2440 Sandy Plains Rd. Bldg. 13, Suite 300 Marietta, GA 30066 or by phone at 770-971-9311. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

### **CLIENT NOTIFICATION OF PRIVACY RIGHTS**

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Jennifer D. Vann, MS, LAMFT

# PHI NOTICE OF PRIVACY RIGHTS

I, \_\_\_\_\_, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

\_\_\_\_\_  
Client Signature or Parent if Minor or Legal Charge                      Date

If Legal Charge, describe representative authority: \_\_\_\_\_

Jennifer D. Vann, MS, LAMFT  
Marietta Counseling for Children and Adults, LLC  
2440 Sandy Plains Rd. Bldg. 13, Suite 300  
Marietta, GA 30066  
770-971-9311

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual home. Please complete only the top half of this form.

**I wish to be contacted in the following manner (check all that apply):**

**Home Phone Number:** \_\_\_\_\_  
 OK to leave message with detailed information  
 Leave message with name & call back number only  
 Do not leave messages at home number

**Written Communication**  
 OK to mail to my home address  
 OK to mail to my work/office address  
 OK to fax to this number \_\_\_\_\_

**Work Phone Number:** \_\_\_\_\_  
 OK to leave message with detailed information  
 Leave message with name & call back number only  
 Do not call me at work

**Cell Phone Number** \_\_\_\_\_  
 OK to leave message with detailed information  
 Leave message with name & call back number only  
 Do not call me at this number.

\_\_\_\_\_  
Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.**

**RELEASE FOR PHOTOGRAPHING & USING ART WORK**

Jennifer D. Vann, MS, LAMFT

I do hereby give my consent to have my work photographed, videotaped or filmed subject only to the condition that I will not be identified by name on any art, objects, slides, or photographs thereof. I understand that only my age and/or sex will be used as personal identification; any names will be masked. I understand these photograph(s), slides, or video/film(s) may be used for presentations, case consultations, publications, educational and/or research purposes by Jennifer D. Vann, MS, LAMFT. I further release Jennifer D. Vann, MS, LAMFT from all claims for right of publicity, invasion of privacy and libel in connection with the use of these or other written materials. I also agree to indemnify and hold harmless Jennifer D. Vann, MS, LAMFT from any and all liability that may arise in connection with the use of these stated materials. Furthermore, I understand that no remuneration of any type will be given to me by Jennifer D. Vann, MS, LAMFT for use of these materials and I agree that I will not claim any further remuneration for use of these materials.

\_\_\_\_\_  
Minor's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adult's Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Parent/Legal Guardian's Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date

## **DIRECTIONS**

to Marietta Counseling for Children & Adults, LLC.  
*2440 Sandy Plains Rd. Building 13, Suite 300*  
*Marietta, GA 30066*  
*770-971-9311*

\*\*Please note that Google Maps and Map Quest do not give accurate directions to our office\*\*

**From I-75:** Exit 267A. At first light you will turn right onto Sandy Plains Rd. Go through 5 stop lights. Pass Keswyck Commons Neighborhood and just past Mozelle St. and then a grave yard on your right you will look for the big Travel Leaders sign and turn right into the office park. Go to the first stop sign and turn right. Building 13 is the second building on your right.

**From Barrett Parkway:** Travel southeast on Barrett. It will turn into East Piedmont. As you approach Sprayberry H.S. on your right you will turn right onto Sandy Plains Road. Turn left at the first break in the median onto First Street and then take an immediate right into the office park. Go through the stop sign. Building 13 is the second building on the right.

**From East(er) Cobb:** Travel East Piedmont off of Sewell Mill or 120 heading northwest until you come to Sandy Plains Rd. Turn left at the first break in the median onto First Street and then take an immediate right into the office park. Building 13 is the second building on the right.

**From Woodstock and Roswell:** From Hwy 92 take Sandy Plains Road west to East Piedmont. Cross over East Piedmont. Turn left at the first break in the median onto First Street and then take an immediate right into the office park. Building 13 is the second building on the right.

**From West Cobb:** From Marietta Square make your way toward Kennestone Hospital passing Kennestone on your left and crossing over I75 on Canton. At first light you will turn right onto Sandy Plains Rd. Go through 5 stop lights. Pass Keswyck Commons Neighborhood and just past Mozelle St. and then a grave yard on your right you will look for the big Travel Leaders sign and turn right into the office park. Go to the first stop sign and turn right. Building 13 is the second building on your right.