

Jodi Ashton, MFT 42404

Phone: 619.517-5684

9541 Grossmont Summit Drive, La Mesa, CA 91941

CLIENT INFORMATION

Date of 1st Appointment: _____ Referral Source: _____

(Please indicate all those participating):

ADULTS

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	OCCUPATION	RELATIONSHIP TO CLIENT (or Self")

CHILDREN

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	LEGAL GUARDIAN	RELATIONSHIP TO CLIENT (or "Self")

Home Address _____

City/State/Zip: _____

(OK to
contact you here?)

Phone #s: Home: _____

Cell: _____ (Y__ N__)(msg__

Email: _____ (Y__ N__)(msg__)

Appointment Reminders can be sent via: ____ Text (list cell phone carrier _____) OR ____ E-mail

Emergency Contact Person: _____

Relationship to
Client/Family: _____ Contact
#: _____

Primary Care Physician: _____

Physician's #: _____

Medications/For What: _____

Person Responsible for Payment:

_____ (Continued on next page)

1. Please describe your reasons for seeking therapy at this time. If there is a particular event or situation which triggered your decision, please describe the event:

Please rate the severity of the following symptoms over the last month according to the following rating scale: **0-No difficulty 1-Mild 2-Moderate 3-Severe**

____ Decreased appetite ____ Nightmares
____ Increased appetite/eating more ____ Hypervigilance
____ Binging and/or purging ____ Obsessive thoughts
____ Weight change? +/- ____ lbs. ____ Compulsions
____ Depressed mood ____ Spending sprees
____ Decreased energy/fatigue ____ Racing thoughts
____ Sleep changes: trouble falling asleep; ____ Rapid heart beat
trouble staying asleep; trouble ____ Trouble breathing
waking up (circle one) ____ Sweating
Avg. # hours sleep ____ ____ Gambling
____ Decreased sexual desire ____ Police/Probation involvement ____
Difficulty with sexual functioning ____ Stealing
____ Loss of interest in activities ____ Lying
____ Crying ____ Truancy
____ Feelings of hopelessness ____ Violent behavior towards ____
Feelings of helplessness others
____ Decreased attention span ____ Destruction of property
____ Inattentive/Distractible ____ Harming animals
____ Memory problems: Long-term; short term ____ Fire setting
____ Opposition
____ Self-injurious behavior ____ Anger outbursts
____ Thoughts of suicide ____ Irritability
____ Thoughts of harming others ____ Substance Abuse
____ Impulsivity ____ Alcohol
____ Hyperactivity ____ Illicit Drugs
____ Anxiety/Nervousness ____ Prescription Drugs ____ Worry/Fear ____
spending time with others ____ Flashbacks of traumatic event ____
Self-esteem
____ Difficulties making decisions ____ Phobia/Fears

3) Please identify any history of abuse/trauma:

_____ Physical Abuse _____ Sexual Trauma _____ Emotional Abuse
_____ Witnessed Violence _____ Combat Trauma

4) What would you like to see accomplished in therapy?

5) Have you or other members of your family ever received counseling or mental health services before? If so, please list dates, provider name, the issue for which services were sought, and what you feel was accomplished:

6) Please list any medications and/or other treatments you are receiving at this time (i.e., prescription/over-the-counter medications, medical care, acupuncture, chiropractic care, substance abuse treatment, etc.):

7) ****Insurance Information (if applicable):**

Person Responsible for

Payment _____ Insurance

Company: _____ Phone _____

Patient's ID# _____

Group #: _____

Subscriber's Name: _____ Phone #: _____

Subscriber's Address:

____ Subscriber's SS#:

____ Subscriber's DOB: _____

Subscriber's Employer's Name:

____ Subscriber's Relationship

to Patient: _____

Informed Consent and Disclosure Statements

Jodi Ashton, MFT 42404

Welcome to my practice. This document contains important information about my professional services and policies. Please read the entire document carefully and ask any questions you have regarding its contents.

Information About Me

Prior to beginning treatment, I will discuss my professional background and provide you with information regarding my experience, education, special interests, and professional orientation.

I am a **Licensed Marriage and Family Therapist, MFT42404**

Information About My Practice

I am a Sole Proprietor. The name of this business is Jodi Ashton, MFT.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. We are partners in the therapeutic process. As partners, we will work together to develop a plan for your treatment. Based on the information you provide to me and the specifics of your situation, I will offer feedback and recommendations regarding your treatment and progress.

Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. While I hope our work together will be effective, the amount and length of treatment varies from patient to patient. I am unable to predict how long you will be in therapy or guarantee a specific outcome or result of our work together. Therapy sessions are approximately 45-50 min each. Typically, sessions are scheduled once per week, at the same day and time each week. Consistent attendance contributes greatly to a successful outcome

Fees and Insurance

The fee for service is \$ 200 per individual therapy session.

The fee for service is \$ 200 per conjoint (marital /family).

Fees are payable at the time that services are rendered. I accept payment in the form of Debit Card, Credit Card, and Health Flex Spending Account. It is my goal to maximize your session time. Therefore, if you are paying for a session via a debit card, credit card, please let me know ahead of time so I can collect and/or provide the necessary information.

You are ultimately responsible for payment for services received, even if you are relying on, or expecting your insurance company or another third-party payor to cover the costs of your treatment. I will notify you in the event of any changes to fees or when other charges are to be applied. If you are experiencing financial difficulty, please let me know so we can discuss your options for care.

Please inform me if you wish to use health insurance to pay for your services. If I am a contracted provider with your insurance company, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or co-insurance payments depends on the requirements of your specific insurance plan. Please be aware that insurance plans generally limit coverage to diagnosable mental conditions. You are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee that your insurance will provide payment for the services provided to you.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur once per week on the same day at the same time, if possible. I may suggest a different amount or frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance can greatly contribute to a successful therapy outcome. To cancel or reschedule an appointment, please notify me at least **24 hours** in advance of your appointment. If you do not provide me with at least **24 hours'** notice of a cancellation, I will charge you the **\$ amount that I would be paid for the session** for the missed session. If you are using insurance, please be aware that your insurance company will not pay for missed or cancelled sessions. Accordingly, you will be responsible for covering the cost of missed sessions and sessions cancelled within **24 hours** of the scheduled session. If you are past **15 min** late to a session it will be considered a No Show and you will owe for the session.

Your Right to Confidentiality

As a psychotherapy patient, you have a right to confidentiality with respect to information related to our work together. Accordingly, information shared between us will generally remain confidential.

Exceptions to Confidentiality

In certain, limited instances, the law requires me to disclose information pertaining to my work with you. For example, as a therapist I am required to report suspected child, elder, and dependent adult abuse. Please note that the legal definition of "child abuse" generally includes instances of "sexting" in which a person of any age captures, records, sends, receives, or possesses an image or video depicting a minor engaged in sexual or otherwise obscene conduct.

Similarly, in the event that I believe you present a serious and imminent danger to yourself, another person, or the public, I may be required to disclose information to emergency medical services, law enforcement, and/or another third party that can help to reduce or prevent that danger.

Confidentiality and Treatment of Minors

If a minor's parent(s) or guardian(s) give consent for me to treat the minor, I typically provide the parent(s) or guardian(s) with general updates about the minor's treatment. These updates may include the minor's diagnosis, treatment plan, progress in therapy, session attendance, or similar information. However, I generally do not share specific details about the minor's treatment or what the minor has shared with me during sessions unless: 1) the minor gives me permission to disclose such information and I believe the disclosure would be clinically appropriate; or 2) the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

If the minor consents to their own treatment, the law generally prohibits me from communicating with their parent(s) or guardian(s) without written authorization from the minor unless the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

Please feel free to reach out to me if you have questions about these policies or if you would like to discuss them further.

Confidentiality and Couples / Family Therapy If you are participating in couples or family therapy, please be aware that, in most circumstances, the law prohibits me from disclosing confidential information and records regarding the unit of treatment's services unless all identified patients provide written authorization to release the information.

No Secrets Policy

I would also like for my couples and family therapy patients to be aware that I utilize a "no-secrets" policy. This means, when I determine it is clinically appropriate or necessary to do so, I am able to disclose information I obtain from one member of the couple, or a participating member of the family therapy unit, (i.e. the "treatment unit") with the other member(s) of the treatment unit. This policy also applies to information a member of the treatment unit shares with me outside of couples / family sessions (e.g. via email, text, etc.) and information I obtain during individual session(s) with a member of the treatment unit (should we agree to hold individual sessions in furtherance of your couples / treatment goals). I find that this policy facilitates effective communication with and between my couples and family therapy patients. It also helps me to avoid potential problems which may arise when a therapist is perceived to be "keeping secrets" from other members of the treatment unit.

My Communication With You

From time to time, I may need to communicate with you outside of our sessions together to discuss scheduling, payment, or other issues related to your treatment. To respect your privacy, it is important for me to understand your communication preferences. Please indicate your openness to receive communication from me via the following methods:

Phone My Home Phone Number is _____

☐ I authorize my therapist to call me at this number

☐ I authorize my therapist to leave messages for me at this number

My Cell **Phone** Number is _____

☐ I authorize my therapist to call me at this number

☐ I authorize my therapist to leave messages for me at this number

Additional Information About Unencrypted Text Messaging: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted text, such as technological failures or unintended access by third parties.

☐ I understand the information above and authorize my therapist to communicate with me via unencrypted text using the cell phone number I provided.

Email My Email Address is _____

Additional Information About Unencrypted Email: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted email, such as technological failures or unintended access by third parties.

☐ I understand the information above and authorize my therapist to communicate with me via unencrypted email at the email address I provided.

Mail My Home Address is _____

☐ I authorize my therapist to send necessary, treatment-related information to me at this address.

Additional Communication Information and Preferences

Please feel free to inform me if there are additional communication preferences you would like for me to be aware of, or if you do not wish to be contacted at a particular time, place, or by a particular means.

I will do my best to honor your communication preferences, but please be aware that in certain instances, such as emergency circumstances, I may need to reach you through other methods.

Emergency Contacts

It is critical for me to know who I can contact in the event that you are experiencing a medical or psychiatric crisis or other emergency circumstance. Please identify these individuals in the space provided below:

Emergency Contact 1

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Emergency Contact 2

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Your Communication With Me

Outside of our sessions together, my preferred methods of communication are as follows:
619-517-5684, text or call. Jodi Ashton, MFT, 9541 Grossmont Summit Drive, La Mesa, CA 91941

Nonurgent Communications

If you would like to contact me in-between sessions to discuss a nonurgent issue, such as scheduling or payment, please do so during my normal business hours of Monday-Friday 8-5

Please understand that I may be in session with other patients or addressing other matters when you attempt to reach me. If you send or leave me a message, I will respond as soon as I am available, but please be aware that I may respond to your communication up to 48 hrs after receiving your message.

Urgent / Emergency Communications

If you are ever experiencing a medical or psychiatric emergency or if you are facing an emergency involving a threat to your safety or the safety of someone else, please call 911 to request emergency assistance. In the event of a mental health crisis, you may also call the 988 Suicide & Crisis Lifeline by dialing "988."

Therapy Across State Lines

Unfortunately, I may not be able to treat you while you are physically outside of the state of California. My ability to do so depends on various factors, such as the laws of the jurisdiction you will be traveling to. If you know you will be traveling outside of the state, please provide me with as much advance notice as possible so I may have enough time to determine whether I will be able to provide treatment to you during that time.

If you are paying for therapy via health insurance, Medi-Cal, or another third-party payer, advance notice of your travel plans will also allow us to discuss whether your plan covers therapy across state lines and/or alternative payment options, if necessary and appropriate. Please be aware that not all plans cover therapy across state lines.

If I am unable to treat you while you are outside of California, we can discuss alternative care options and strategies as well as what you should do in the event of an emergency.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on your clinical needs, the specifics of your treatment plan, and the progress you make towards achieving your treatment goals. While I hope you will find our time together beneficial and meaningful, I cannot guarantee the specific outcome(s) or result(s) your treatment will yield.

You may discontinue therapy at any time. If one of us determines you are not benefiting from treatment, we can discuss treatment alternatives. These alternatives may include, among other

possibilities, changes to your treatment plan, referrals to other therapists, and/or termination of treatment.

Questions About My Policies

Please let me know if you have any questions about my policies or if you would like to discuss them further.

Informed Consent

Your signature below indicates that you have read this agreement for services and disclosures carefully, understand its contents, and consent to receive treatment from me.

Name_____

Patient's Name (If You Are Not the Patient)_____

Relationship to Patient (If Applicable)_____

Signature_____Date._____

A Message to My Clients About Arbitration

Please Read Before Continuing to Arbitration Agreement

The attached contract is an arbitration agreement. By signing this agreement, we are both agreeing that any dispute arising out of the services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. I believe that the method of resolving disputes by arbitration is one of the fairest systems for both clients and providers. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the place where your claim will be presented. You are not forfeiting your right to file a claim should you feel the need arises. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and providers. Further, both parties are spared some of the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal is always to provide mental health services in such a way as to avoid any such disputes. Still, we know that most problems begin with miscommunication. If you have any questions at any time about your care, please ask us immediately.

Please sign/initial the highlighted areas below. A copy of this agreement will be provided to you upon your request.

THERAPIST-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical/mental health services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on in a court of law

before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the therapist, and the therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the therapist within 30 days, or signature. It is the intent of this agreement to apply to all medical/mental health services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical/mental health services.

Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU WISH TO HAVE A COPY OF THIS CONTRACT, YOU MUST REQUEST ONE. PLEASE NOTIFY YOUR PROVIDER AND A SIGNED COPY WILL BE PROVIDED.

By _____ By: _____

Provider's Signature (Date) Primary Patient's or

Representative's Signature (Date) By: _____ By: _____

Printed Name of Provider Printed Patient's Name

By: _____ Printed Representative's Name and Relationship to Patient

Credit Card Information

The undersigned hereby authorizes Jodi Ashton, MFT, to charge my credit card (provided below) for the amount of the therapy session, or co-pay, if there is an outstanding balance more than 15 days after the date of service.

I understand that by signing this authorization, I give Jodi Ashton, MFT, permission to charge my credit card in the amount of the “full session fee” (this may be more than your usual copay) for a missed appointment without notice or any cancelled appointment that is within 24 hours of the scheduled time. I understand that this amount can be charged on the day of the missed appointment.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you pay by cash or check by the time your payment is due. The credit card to remain on file is:

- Please Circle:

MasterCard Visa Discover

- Card Number: _____
- Expiration Date & Zip Code of card: _____
- Security Code: _____ (3 digits on back of card)
- Name as appears on the card: _____
- Billing Address with zip code:

- Signature of card holder: _____

The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____