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: _____ *(Y__ N__)(msg___)*

Work: _____ *(Y__ N__)(msg___)*

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
_____ Increased appetite/eating more
_____ Binging and/or purging
_____ Weight change? +/- _____ lbs.
_____ Depressed mood
_____ Decreased energy/fatigue
_____ Sleep changes: trouble falling asleep; trouble staying asleep; trouble waking up (*circle one*)
Avg. # hours sleep _____
_____ Decreased sexual desire
_____ Difficulty with sexual functioning
_____ Loss of interest in activities
_____ Crying
_____ Feelings of hopelessness
_____ Feelings of helplessness
_____ Decreased attention span
_____ Inattentive/Distractible
_____ Memory problems: Long-term; short term
_____ Opposition
_____ Self-injurious behavior
_____ Thoughts of suicide
_____ Thoughts of harming others
_____ Impulsivity
_____ Hyperactivity
_____ Anxiety/Nervousness
_____ Worry/Fear
_____ Flashbacks of traumatic event
_____ Difficulties making decisions

_____ Nightmares
_____ Hypervigilance
_____ Obsessive thoughts
_____ Compulsions
_____ Spending sprees
_____ Racing thoughts
_____ Rapid heart beat
_____ Trouble breathing
_____ Sweating
_____ Gambling
_____ Police/Probation involvement
_____ Stealing
_____ Lying
_____ Truancy
_____ Violent behavior towards others
_____ Destruction of property
_____ Harming animals
_____ Fire setting

_____ Anger outbursts
_____ Irritability
_____ Substance Abuse
  _____ Alcohol
  _____ Illicit Drugs
  _____ Prescription Drugs
_____ spending time with others
_____ Self-esteem
_____ 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) ****<u>Insurance Information</u>** ***(if applicable)*****<u>:</u>**

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: _____

Secondary Insurance? _____

**Please note: If you choose to utilize your medical insurance for payment, a mental health diagnosis will have to be assigned in order for insurance to cover services. If you have questions about this, you can ask me, or refer to our website for further information.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

Welcome to my practice. This packet contains important information about my professional services and business policies. I believe that a person who understands and participates in his or her care can achieve better and quicker results. Please read this carefully and jot down any questions you might have so that we can discuss them at our next meeting.

Introduction

Jodi Ashton is a Licensed Marriage and Family Therapists and in the state of California. She specializes in working with couples, children, adults, and families. She offers individual, couples and family therapy.

IF YOU HAVE AN EMERGENCY

Call 9-1-1 or go to your nearest emergency room. If you have a crisis and you need to speak with someone immediately, call 1-888-724-7240 and someone will assist you. If you absolutely must speak with one of the therapists please leave a message on their direct line and your call will be returned as quickly as possible. PLEASE NOTE your call may not be returned for up to 24 business hours. When your therapist is on vacation or out of the office for any reason, the therapists direct line outgoing voicemail will provide instructions on how to deal with urgent matters. Phone calls and emails will not be returned until your therapist returns to the office in those cases. **In case of crisis, emergency or urgent matters please call - DO NOT text or email.** Routine (non-emergency/non-urgent) messages will be responded to within 24-48 business hours.

Therapeutic Services

Sessions typically last forty-five to fifty(45-50) minutes. Duration of treatment will depend on your needs, your treatment goals, and other factors related to your treatment responsibilities. As with any type of growth or change process, individual factors can significantly impact the rate and the degree of effectiveness of the therapeutic process. We will discuss your progress throughout treatment, including expected length of therapy. Weekly sessions are generally recommended for the first 4 to 6 visits but may be necessary for longer. If you have any specific scheduling needs, it is strongly recommended that you schedule several visits in advance in order to avoid lapses in treatment and to ensure convenient appointment times. Therapy is strictly voluntary in nature. You have the right to terminate therapy at any time. A therapist may also choose to terminate therapy for a variety of reasons. If therapy is terminated by therapist, you will be provided with at least three referrals for alternative therapists.

What to expect in therapy session

During the first couple of sessions the therapist will be gathering information and creating treatment goals with you. Therapy works best when you have specific goals you wish to accomplish and you and your therapist work together to develop a treatment plan to achieve your goals. During the time between sessions it is beneficial to think about and work on what was discussed. At times, you may be asked to take certain actions outside of the therapy sessions such as reading a relevant book or keeping records. For therapy to "work," you must be an active participant, both in and outside of the therapy sessions.

Fees

The fee for direct clinical services will be $125.00 per session. It is customary to pay for professional services at the time they are rendered. You may pay by cash, check, or credit/debit card made payable directly to your therapist. If at any time you experience difficulties making your payment, we will be glad to discuss your concerns with you. In the event your check is returned for non-sufficient funds, you will be expected to pay for services by cash or money order and will also be charged a $35.00 fee for your returned check. Please be advised: if your insurance carrier denies payment for services rendered, you will be responsible for payment in

full. There may be circumstances under which you may be billed for time outside your actual therapy sessions, such as consultation time between your therapist and other professionals working with you, telephone consultations that last more than five (5) minutes, special reports and psychological evaluations, and other services deemed necessary for continuity of your care and effectiveness of treatment. Letters and reports that I complete on your behalf will be billed in half-hour (1/2 hour) increments of my normal hourly fee ($120/$135) for the service. You will be notified of additional charges before they are incurred. These charges are not covered by your insurance company, and therefore, you are fully responsible for payment.
Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be electronically billed for you and Jodi Ashton, will be paid directly by the carrier. You will be responsible for any applicable deductibles and copayments at the time of service, prior to the session beginning.

Cancellation Policy

If you are unable to attend your session for any reason, please notify us at least 24 hours in advance. Failure to do so will result in a full appointment fee and will either be charged to your card on file or expected to be paid at your next session. Insurance companies do not reimburse for missed sessions, therefore this will be your responsibility. Appointments may be cancelled by leaving a voice mail on your therapist's direct voicemail 24 hours a day, 7 days a week. If you are cancelling via text or email, please also call if you do not receive confirmation that your therapist received your message.

Confidentiality and Mandated Reporting

All information exchanged between patient and therapist is considered strictly confidential. We will not release any information about your therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws
2. The patient presents an imminent danger to himself or herself or to others
3. There is any reason to suspect the abuse or neglect of a child, dependent adult or elderly person
4. As necessary for continuity of care
5. As required to collect payment for services
6. If a judge determines that our discussions are not confidential, the judge may order that specific information be released
7. As requested by a court appointed attorney for a child involved in court proceedings.
8. If you are bringing your child for treatment, it is up to the therapist to determine the level of confidentiality he or she will require. As a general rule, children ages 12 and up will retain confidentiality from their parents, prohibiting me from discussing the content of our sessions with parents. (Except in the cases of numbers 2 and 3).
9. If you participate in couples counseling as part of your treatment, please be advised that no information will be released without the written consent of both parties. As a standard, I will follow the "minimum necessary" rule for information being released.
10. No Secrets Policy: When working with couples it is essential for the effectiveness of treatment that you know we do not keep secrets from partners in couples. Should we happen to speak with either party individually the content of those conversations will not be kept secret from the partner/spouse. The only exception is if there is an immediate or ongoing safety issue.

In the cases of numbers 2 and 3, Jodi Ashton is mandated by law to inform potential victims and legal authorities so that protective measures can be taken.

Health Insurance and Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form provided to you (located on our website) with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purpose of treatment and payment. Jodi Ashton has no control or knowledge over what insurance companies do with the information we submit or who has access to this information. You must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

Electronic Communication

E-mail

Many people feel comfortable communicating via e-mail. However, there may be risks involved. There is no guarantee that spyware or other such programs will work 100% of the time. All e-mails will be stored on a password protected account that only your therapist will have access to. Although we have no reason to

believe that our e-mail communications will be read by any third party, communication via e-mail is, by nature, impossible to completely secure and it is possible that my e-mail may be accessed by a third-party without the knowledge of Jodi Ashton. If you agree to e-mail communications, Jodi Ashton, MFT, will not be held liable for breach of confidentiality should these messages be viewed. Should you choose to send an e-mail containing personal/clinical information, you give Jodi Ashton, permission to respond by referencing the information you have included.

Text Messages

Do not text your therapist if you have an URGENT OR EMERGENT message or situation. If you would like to use texting for appointment changes, please discuss with your personal therapist as some therapists prefer phone calls only.

Appointment Reminders

You have the option to receive an automated e-mail or text reminder of your appointment. If you have provided a valid cell phone number you will receive a text message reminder. If you prefer an e-mail reminder, please provide a valid e-mail address. If you have not provided this information you will not receive an appointment reminder. Reminder messages are a COURTESY only – it is your responsibility to keep track of all appointments. Even if you do not receive a reminder you are still responsible for all late cancellation/no-show fees.

Social Networks/Dual Relationships

I understand that as a matter of policy, that Jodi Ashton, MFT will not accept friend requests or any other request to be added to any social network (including, but not limited to; Facebook, Twitter, LinkedIn and Google+). In addition Jodi Ashton, MFT does not engage in friendships and/or business relationships with clients outside of their treatment, even after treatment has terminated.

Consultation

In order to provide you with the best care possible, Jodi Ashton, MFT will periodically meet with each other and/or other licensed mental health providers to discuss their cases. If your case is discussed, every effort will be made to keep identifying information confidential.

Appeals and Grievances

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) is denied certification by my insurance company. I understand that I would request an appeal through my therapist and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to Jodi Ashton, MFT at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit grievance to my insurance directly or to the California Board of Behavioral Sciences at 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 or at 916-574-7830.

AGREEMENT FOR SERVICES

After reading and understanding the information above, please acknowledge your consent to begin services by initialing and signing the following agreement:

I have read, understand, and agree to the policies and procedures described above. _____ (initial)

I have received/reviewed a copy of HIPAA regulations. _____ (initial)

I have read and understand the PHONE, E-MAIL and TEXT policies and consent to e-mail or text reminders. _____ (initial)

I understand that regular attendance will produce the maximum possible benefits but that I am free to discontinue treatment at any time in accordance with the policies of this office. I understand that a 24-hour notice is required for cancellation of my scheduled appointments. I agree to pay the full fee for services for any missed appointments or late cancellations. _____ (initial)

I agree to pay any fees at the beginning of each appointment. I understand that if for any reason my insurance does not cover services, I am responsible for payment, even if this determination is made after services are rendered. ____ (initial)

If I am consenting on behalf of a minor child, dependent or beneficiary, I hereby authorize Jodi Ashton, MFT to deliver mental health services to the patient. I understand that all policies stated in this packet apply to the

patient(s). I further accept that although my participation may be required as part of the patient's treatment, the patient's records are confidential, and by law I cannot access these records Jodi Ashton, MFT, believes such access would be detrimental to the patient. _____ (initial)

I authorize Jodi Ashton, MFT to release medical or other information necessary to process insurance claims for services rendered as part of my treatment. _____ (initial)

I have been informed and understand the limits of confidentiality, which include mandated reporting situations. _____ (initial)

By signing below, I consent to psychotherapy with Jodi Ashton, MFT.

Printed Name	D.O.B.	Signature	Date
Printed Name	D.O.B.	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 arbitrations 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 of 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: _____