Nicole Ashton, MA, MFT, CSAT, CCPS
Certified Sex Addiction Therapist
Certified Clinical Partner Specialist
Licensed Marriage and Family Therapist MFC # 45884

CONFIDENTIAL CLIENT INFORMATION

Today's Date:_____

GENERAL INFORMATION

Name:_____
Date of Birth:_____ SS# _____
Address:_____
City:_____ Zip Code:_____
Phone/Cell _____ Okay to Text? Yes_____ No _____
Email:_____

Is it OK to contact you by email? (Please note that email correspondence is not guaranteed to be confidential) Y_____ N_____

EDUCATION AND RELATIONSHIP INFORMATION

Employer name and address:
_____
_____
_____
Job title:_____
Highest level of education completed:_____
Marital Status: _____ Name of Spouse/Partner:_____
Children? Y _____ N _____
If yes, please tell me their genders and ages:_____
Who do live with? _____
Who referred you to my practice?_____
_____

MEDICAL INFORMATION

Regular Physician (Name & Phone): _____
_____
_____

Psychiatrist (Name & Phone): _____
_____
_____

Will you sign a Release of Information should a conversation/consultation become necessary?
Y _____ N_____
List medications you are currently taking - including non-prescription or herbal supplements
_____
_____
Any physical health concerns I should be aware of? _____

Emergency contact:
Name:_____
Address:_____
_____
Phone:_____
Relationship:_____

Reason you are seeking therapy at this time. _____
_____
Have you had therapy before? Y _____ N_____
If so what kind of therapy? Inpatient _____
Outpatient _____
Length of Treatment _____
Date(s) _____

Briefly describe concerns in your life and/or in your relationships that would be relevant for me to know:
_____
_____
_____
_____

On a scale of one to ten, how motivated are you to resolve this issue? _____
Please list your therapy goals (list as many that apply & use the back if need be):
1.
2.

FEE, BILLING AND PAYMENTS

Payment for professional services is expected at the time of each session.

Monthly statements will be provided upon request. Clients are responsible for submitting all claims to their insurance carrier.

It is important to remember that a 24- hour notice is required to re-schedule or cancel an appointment. The full fee will be charged for sessions missed without such notification.

I,_____, am authorizing Nicole Ashton, MA.,MFT #45884 to charge the full agreed upon session fee (including a $6 per transaction service fee) to the credit card indicated below in the event that I do not attend a scheduled therapy appointment without giving a minimum of 24 hours notice.

I understand that this authorization is valid until canceled in writing. I understand that charges for on-going services will normally be posted to my credit card account within 24 hours of each session date and **my session fee will be charged at the start of the day on the day of my session.**

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Nicole Ashton, MA, LMFT for assistance and/or disclosure.

Initial _____

I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Nicole Ashton, MA, LMFT and those attempts have failed.

Initial _____

I agree and understand that I am individually responsible for all incurred charges even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

Initial _____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Nicole Ashton, MA, LMFT.

Initial _____

PAYMENT INFORMATION

Circle Card Type Visa MasterCard *(NOTE: I do not accept Amex)*

Card Number _____CVV code (3 digits on back) _____

Expiration Date _____

Cardholder Name _____

Billing Address _____

City_____ Zip _____

Relationship to client:_____

I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions:

_____

Name of Client Signature Date

OFFICE POLICIES AND CONSENT FOR TREATMENT

Confidentiality

Your confidentiality is very important to me. Should you request that I speak with another professional or person (i.e. doctors, former therapists, teachers, family, friends or anyone else outside the therapy room), I will ask for your written consent in order to do so and only after determining if this is in the best interest in supporting your therapeutic process and progress.

Legal Exceptions to Confidentiality

Therapy sessions are strictly confidential except under the following:

- When there is reasonable suspicion of child abuse, dependent – adult or elder abuse. In incidents of child abuse, elder abuse, or abuse of otherwise dependent individuals, I must notify the appropriate social service agencies.
- When a client threatens violence to an identifiable victim
- When a client presents a danger of violence to others

- When a client is likely to harm him/herself unless protective measures are taken. I am ethically bound to inform those in a position to help, or to otherwise enlist methods to prevent self-harm or suicide.
- Other situations that require me by law to reveal information about you to others without your consent include if a court of law issues a legitimate subpoena or if you are being treated or tested by court order.

Suicide Policy
If you are suicidal, I will take all reasonable steps to prevent harm to yourself. This may include breaking confidentiality if you pose a serious risk of self-harm to yourself.
Your signature indicates that you have read and understand confidentiality and limits to confidentiality:

Signature _____ Date: _____

Emailing or Text Messaging your Therapist
I check e-mail and text messages approximately twice a day on weekdays and sporadically on weekends and vacations. Please note that while I typically respond within 48 hours, there are times when email and text message replies may take several days when your therapist is away from the office, or occasionally your email may have inadvertently gone to the spam folder. If you have not received a reply within 72 hours, please call Nicole's office at 310.592.8274.

It is important to understand that E-mail and/or text messaging is not an ideal forum for communication of emergencies or crisis situations. Also, in NON-crisis and NON-emergency situations, cell phones, E-mail, and text communication carries risks to confidentiality and security of the e-mail and text messaging contents. ***This means that confidentiality and security cannot be guaranteed***. Your therapist feels that it is in the best interest of the therapist/client relationship to communicate within **your weekly therapy session**.

Therapist Time Off Policy
I will give you at least one weeks notice before my time away. **If you require a higher level of care at this time, please take this into consideration**. During my out of office time, I will not be available for individual session or couples therapy both in person, via email, text or phone unless it is a serious crisis, or life threatening emergency where there is imminent danger to self or others. If you are a threat to yourself or another when I am away, please call 911 immediately. On occasion I may provide the phone number and contact information of a therapist colleague who may fill in during my time away for emergency situations. I ask that clients respect my time away and unless there is a critical emergency, they wait until the next session to discuss. For **emergency** situations, I will respond to the client within 24 hours of receipt of the email, call or text. For **non-emergency** clients, I will respond the first business day upon returning back to my office.

Your signature indicates your agreement to my boundaries around client contact during my time away: _____

Holiday, Weekend and Evening Contact

I will make every effort to return the call, email or text message of a **non-emergency** client message within 24 hours during my work week. If this call, text or email arrives during a holiday, weekend or evening, I will return **the non-emergency** client contact during the first working day following the holiday, weekend or evening. For **emergency only** clients (emergency constitutes imminent danger to self or others) I will make every effort to return the call, text or email within 24 hours and ask that if the client is facing a life threatening emergency that they call **911 immediately**. There will be a regular session fee or partial session fee for emergency phone calls and sessions that are in excess of 5 minutes, or more than 1 time per month.

Consent for Treatment

Client acknowledges that the decision to undergo psychotherapy is voluntary and that client is free to discontinue services at any time. Participating in therapy can result in a number of benefits to you, including improving your personal relationships, resolution of the problems that led you to seek therapy, and increased personal growth and fulfillment. Psychotherapy requires your active involvement, honesty and openness in order to change your thoughts, feelings, and behaviors. Sometimes talking about unpleasant events and memories can cause discomfort. I may challenge you on various assumptions and beliefs that may upset you but I will educate you on how you can use the therapeutic relationship to your benefit. If you wish me to talk with another therapist or provider, you must sign Consent to Release Information.

I have thoroughly read and fully understand the Informed Consent and therapy policies pages of this document.

- **I understand that I am financially responsible for charges and fees incurred**.
- **I understand limits of confidentiality and mandated reporting by my therapist.**
- **I agree to respect the boundaries of contact between sessions and understand email is not an appropriate form of processing what is best discussed in session.**
- **I understand that emailing, texting and cell phone are not guaranteed a confidential.**
- **I have answered all questions in full, truthfully and to the best of my knowledge.**
- **I have had all questions about this document answered and sign willingly.**

- **I authorize Nicole Ashton, Licensed Marriage and Family Therapist to provide psychotherapeutic treatment for me, the client signing below:**

Client Name _____
(Please print)

Signature of Client _____
(or authorized representative)

Date _____

Witnessed By
Nicole Ashton, MFT # 45884 _____
3685 Motor Avenue
Suite 220
Los Angeles, California 90034