Ben L. Ashcraft, MS, LMFT
Licensed Marriage & Family Therapist
1224 S. River Road, B-235
St. George, UT 84790

Office Policies and Informed Consent

Agreement to Counseling Services

CONFIDENTIALITY

Confidentiality: All information disclosed within therapy sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property or is gravely disabled or when client's family members communicate to Ben L. Ashcraft, LMFT, that the client presents a danger to others.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Ben L. Ashcraft, LMFT.

Couples and Family Therapy: In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Ben L. Ashcraft, LMFT will use his clinical judgment when revealing such information and only do so based upon his clinical judgment as to what is best for the couple or family.

Emergencies: If there is an emergency during our work together, or in the future after termination where Ben L. Ashcraft, LMFT becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he will do whatever he can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose he may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct Ben L. Ashcraft, LMFT, only the minimum necessary information will be communicated to the carrier. A diagnostic code for billing purposes as to primary presenting symptom will need to be submitted. The therapist has no control or knowledge over what insurance companies do with the information submitted or who has access to this information.

E - Mails, Cell Phones, Computers and Faxes: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. Additionally, the communications sent by the therapist are not encrypted and can easily be sent erroneously to the wrong address or number. Please notify Ben L. Ashcraft, MS, LMFT if you decide to avoid or limit, in any way, the use of any or all communication devises, such as e-mail, cell phone or fax.

Telephone & Emergency Procedures: If you need to contact Ben L. Ashcraft, LMFT between sessions, please leave a message on his confidential voice mail and your call will be returned as soon as possible. If an emergency situation arises, indicate it clearly in your message, and if you need to talk to someone right away, call the Police: 911. Please do not use e-mail or faxes for emergencies.

Payment & Insurance Reimbursement: Payment is collected at the time of each appointment. Appointment cost is $100 per 50 minute session paid by cash or check. If you pay by credit card, the cost is $103; checks should be made out to "Ben L. Ashcraft". If you are paying by credit card please note cancellation policy about charges in the event of a missed or no-show appointment. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Ben L. Ashcraft, LMFT can use legal or other means (courts, collection agencies, etc.) to obtain payment.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Ben L. Ashcraft, LMFT to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Mediation & Arbitration: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Ben L. Ashcraft, LMFT and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Washington County, UT in accordance with the rules of the American Arbitration Association which was in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Ben L. Ashcraft, LMFT can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum and for attorneys fees. In the case of arbitration the arbitrator will determine that sum.

Records and Your Right to Review Them: Both the law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Ben L. Ashcraft, LMFT assesses that releasing such information might be harmful in any way. Should you request notes, the therapist will be given 30 days to release such material to an appropriate and legitimate mental health professional of your choice.

The Process of Therapy/Evaluation and Scope of Practice: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part, including honesty and openness in order to change your thoughts, feelings and/or behavior. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort and strong emotions. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. Ben L. Ashcraft, LMFT is will draw on various psychological approaches to best assess and treat the presenting problems and assist in creating desired positive change. Note that the therapist provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within his scope of practice.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment Ben L. Ashcraft, LMFT will discuss with you (client) his working understanding of the problem, treatment plan, therapeutic objectives and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures, please ask and you will be answered fully.

Termination: As set forth above, after the first couple of meetings Ben L. Ashcraft, LMFT will assess if he can be of benefit to you. The therapist does not accept clients who, in his opinion, he cannot help. In such a case he will give you a number of referrals, who you can contact. You have the right to terminate therapy at any time, but it is recommended that this be decided in consultation with the therapist. If you choose to do so, the therapist will offer to provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: St. George is a small area and many clients know each other and Ben L. Ashcraft, LMFT from the community. Consequently you may bump into someone you know in the waiting room or into Ben L. Ashcraft, LMFT out in the community. The therapist does not acknowledge working with anyone without their prior consent. Many clients choose their therapist because they knew them before they entered into therapy and/or were aware of his stance on the relevant issues. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it, and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to the therapist if the dual relationship become uncomfortable for you in any way. The therapist will discontinue the dual relationship if s/he finds it interfering with the effectiveness of the therapy or the welfare of the client, as is the client's right as well.

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully.

By signing below you agree you understand to comply with them:

_____	_____	_____
Client Name (print)	Date	Signature
_____	_____	_____
Client Name (print)	Date	Signature
Ben L. Ashcraft, MS, LMFT	_____	_____
Therapist	Date	Signature

Client Information

Please fill out the information below. The information will help me understand better who you are and what you are seeking from counseling. Please fill out this form as completely as possible. If you have any questions, please feel free to ask.

SECTION I: IDENTIFYING INFORMATION Today's Date: _____

First Name Last Name Date of Birth

Address City State Zip Code

Home Phone Mobile Phone Email Address

Is it OK to contact you by email? __Yes, __ No Is it OK to leave a phone message? __ Yes, __ No

Date of birth_____/_____/_____ Male_____ Female_____

__Single, __ Married, __Co-habiting, __Separated, __Divorced, __Widowed

Employed_____ Full-time Student_____ Part-time Student_____Other_____

Occupation _____ Is it OK to contact at work? __Yes,__No Ph. Number: _____

Family Doctor Name/Phone_____

Name of Spouse/Partner_____ Age___ Date of Birth_____

Children: Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No
Name: _____ Age: ___ Lives with you? __Yes, __No

In case of an emergency: Emergency contact person _____

Phone_____ Relationship to you _____

Referred to Ben L. Ashcraft by: _____

Health Insurance Information (information from insurance card)

Subscriber Name:
Policy Holder's Employer:
Policy Holder's DOB: _____, SS#: _____
Identification Number:
Group Number:
Customer Service Phone Number (on back of card):

Section II: PREVIOUS COUNSELING AND MEDICAL HISTORY

Have you ever had treatment by a psychiatrist, psychologist, or counselor in the past? _____ Yes, _____No
If yes, please describe the reasons for treatment.

_____
_____

Please list any medications that you are currently taking (including daily dosage).

_____
_____

What substances do you regularly use? ___Alcohol, ___Tobacco, ___Marijuana, ___Meth, ___Cocaine

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Please describe your primary reasons for seeking counseling/therapy.

_____
_____

Have there been any events that are associated with this problem (traumatic event, relationship ending, etc.): _____
_____

What are 3 Goals you would like to accomplish as a result of attending therapy?

1. _____
2. _____
3. _____

Your current commitment level to therapy? (1 low-10 high) _____ To making personal changes? _____

Are you currently suffering from any of the following? Please check **all** that apply:

__overeating	__restless	__rapid heart rate	__compulsive behaviors
__taking drugs	__depressed mood	__sweating	__fears/phobias
__crying	__trembling/shaking	__anxiety	__recent weight loss
__shortness of breath	__excessive drinking	__low motivation	__recent weight gain
__muscle tension	__distrust	__social withdrawal	__difficulty concentrating
__aggressive behavior	__outbursts of temper	__nervous	__sexual dysfunction
__nightmares	__dizzy or lightheaded	__chest pain	__feelings of worthlessness
__stomach problems	__easily distracted	__fatigue/loss of energy	__can't fall asleep
__sleeping too much	__obsessions	__compulsive behavior	__decreased need for sleep
__poor self-esteem	__family problems	__financial problems	__abusive home situation
__problems with school	__housing problems	__marital problems	__pain
__death of a loved one	__childhood trauma	__problems at work	__other traumatic events

other(s):_____