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Psychotherapist-Client Agreement for Services

Full name:____
PLEASE PRINT

Please initial each statement and put your full signature at the end of the document indicating that you have been given a copy of the Psychotherapist-Client Agreement.

I understand Dr. Ashkins uses electronic communication during the routine course of treatment to include, but not limited to: fax, text, and e-mail. I also understand beginning 10/1/15, Dr. Ashkins has been required by the federal and state standards of practice to utilize electronic medical records (EMR) and electronic billing. I understand that every effort is made to protect my privacy and confidentiality during all of these activities and all HIPAA policies strictly apply.

I also understand that as a clinician, Dr. Ashkins is a mandatory reporter in specific (potentially) dangerous situations and in rare cases may need to disclose information to authorities; my initials below indicate I have been informed of these situations, which include:

- **If Dr. Ashkins has reason to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect or that abuse or neglect was a contributing factor in a child's death, the law requires that she file a report with the appropriate government agency, usually the Louisiana Department Social Services. Once such a report is filed, she may be required to provide additional information.** __________

- **If Dr. Ashkins has cause to believe that a dependent adult or elderly individual's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, or exploitation, the law requires that she report to the appropriate government agency, usually an adult protective agency. Once such a report is filed, she may be required to provide additional information.** ____________

- **If a client communicates a significant threat of physical violence to an identifiable victim, Dr. Ashkins may be required to take protective actions. These actions may**

include notifying the potential victim, contacting the police, or seeking hospitalization for the client. ___________

- If a client communicates suicidal thoughts with a specific plan of action or threatens to harm himself/herself, Dr. Ashkins may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. ___________

- I understand that Dr. Ashkins has a challenged immune system and that if I am ill, symptomatic or have tested positive for COVID in the past month, I will convert my session to a virtual appointment. __________
- I understand that Dr. Ashkins that Dr. Ashkins frequently has a waiting list and I am responsible for my appointment time once booked and shall allow 24 hour's notice to avoid charges.

I agree that I am seeking consultation from Dr. Ashkins with the intention of self-improvement and/or improving my current relationship. I therefore agree that I will not request or require Dr. Ashkins to testify in court in any form or fashion regarding my personal situation.

____ ______________________________

SIGNATURE DATE