



Your participation in treatment and for all information about you is confidential and will not be disclosed to anyone without your written consent. Your Rights and the “exceptions to confidentiality” are explained below:

Client’s Rights

As a client of an Oregon licensee, you have the following rights:

- *To expect that Licensee has met minimal qualifications of training and experience required by state law.
- *To examine public records and to have the Board (OBLPCT) confirm credentials of a licensee.
- *To obtain a copy of the Code of Ethics;
- *To report complaints to the Board;
- *To be informed of the cost of services before receiving services;
- *To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.
- *To be assured of the privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
 - 1) Reporting suspected child abuse;
 - 2) Reporting imminent danger to client or others;
 - 3) Reporting information required in court proceedings or by client’s insurance company, or other relevant agencies;
 - 4) Providing information concerning licensee case consultation or supervision;
 - 5) Defending claims brought by client against licensee;

Emergency Procedures: In the event of an emergency, call (503)502-8593. I receive messages from 8am to 7pm on weekdays and once a day on weekends and holidays. If you are having a life-threatening crisis or need immediate psychiatric help, dial the Multnomah County Crisis Line at 503-988-4888 or 911 and/or go directly to the nearest hospital emergency room.

You may contact the Oregon Board of Licensed Professional Counselors at 3218 Pringle Rd SE, #250 Salem, OR 97302-6312. Telephone: (503) 378-5499.

Consent to Treatment

I have read and understand my rights and responsibilities as outlined in the Informed Consent for Treatment and Evaluation form. By signing this form, I also consent to received Mental Health Services and/or Chemical Dependency Services to be provided by Christina Zimmerman, ATR, LPC, CADCI.

Client Name: _____ **Signature:** _____ **Date:** _____
(please print)

Parent or Guardian’s Signature (if minor): _____ **Date:** _____

Witness: _____ **Date:** _____