Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

## Contact Information

Name _____ Date _____
Address _____ Zip: _____
Phone(s) _____ ok to leave detailed vm? _____
Email _____ ok to email you about appointments? ___
Emergency Contact Name: _____ Relationship to you: _____
Their Address: _____ Phone _____

## Client Information

Birthdate _____ Gender Identity _____ Pronouns _____ Sexual Orientation _____
Ethnicity/National Origin _____ Education _____

## Insurance Information

Name of Insured: _____and their DOB: _____ Employer: _____
Insurance: _____ Member ID#: _____ Group#: _____
Address: *if different than above* _____ Zip: _____ (notes?) _____

**How and where do you spend most days?** (work/school/parenting/exercise/volunteering/retired/etc)

**What cultural, religious or other traditions are important to you**?

**What brings you to Art Therapy or Counseling at this time**?

**What are you hoping to gain from this experience**?

**Are you having suicidal thoughts or any other urgent concerns right now**?

**Please list any prescription medications you are taking and for what purpose(s)**.

**Please describe your use of non-prescription drugs and or alcohol- past and present**.

**Are you currently seeing any other mental health professionals? Please describe**.

**Are you currently experiencing physical health concerns? Please list and describe**.

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

**Relationships**

Do you have any history of mental health concerns in your family?

What was your home like growing up? Who lived with you? What were your relationships like?

**Resources**

What are some things going well for you now?

What are some things about you that you feel good about?

What are the activities you enjoy - and how often do you engage in them?

What are the people, places, and activities that bring you emotional and/or spiritual support?

**Any other significant information about your life and experience that you'd like me to know?**

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

# CHECKLIST TREATMENT PLAN

**Client Name:**_____ **Date:**_____

**Problem(s):**

- ❑ Alcohol Use
- ❑ Appetite (increased)
- ❑ Appetite (decreased)
- ❑ Attention
- ❑ Childhood experiences
- ❑ Communication
- ❑ Concentration
- ❑ Dating
- ❑ Drug Use
- ❑ Energy
- ❑ Family conflict
- ❑ Fearfulness
- ❑ Friends/Social life
- ❑ Fulfillment
- ❑ Health
- ❑ Identity
- ❑ Loneliness
- ❑ Motivation
- ❑ Nightmares
- ❑ Organization
- ❑ Overwhelm
- ❑ Parenting
- ❑ Relationships (partner/spouse)
- ❑ Relationships (other)
- ❑ Sadness
- ❑ School
- ❑ Self harm/Intent to harm
- ❑ Sexuality
- ❑ Sleep
- ❑ Thinking
- ❑ Time Management
- ❑ Trauma
- ❑ Work
- ❑ Worry
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

**Goal(s):**

- ❑ Client will reduce symptoms of: _____
- ❑ Client will increase coping skills of: _____
- ❑ Other: _____ _____

**Client Participation(1-3):**

- ❑ Communication with spouse/partner/family
- ❑ Exploring and expressing feelings
- ❑ Journaling
- ❑ Practice skills learned in session
- ❑ Reflect on therapy sessions
- ❑ Review progress made
- ❑ Sharing concerns, thoughts, feelings about therapy

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

**Strengths/Resources (list):**

_____

**Planned Interventions (3-4):**

- ❑ Anger Management
- ❑ Art Therapy
- ❑ Building Support System
- ❑ Cognitive Restructuring
- ❑ Communication Training
- ❑ Decision Clarification
- ❑ Developing Coping Strategies
- ❑ Exploration of Feelings
- ❑ Involvement of Significant Others
- ❑ Grief Work
- ❑ Homework Assignments
- ❑ Imagery/Relaxation Training
- ❑ Mindfulness
- ❑ Play Therapy
- ❑ Practice/Teach Skills of: _____
- ❑ Problem Solving Skills Training
- ❑ Provide Referrals: _____
- ❑ Psychoeducation
- ❑ Role Play
- ❑ Solution Focused Techniques
- ❑ Somatic Work
- ❑ Stress Management
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

Other: _____

*Coordination of Care With (as applicable):*

- ❑ Nutritionist/Dietician
- ❑ Other therapist
- ❑ Parent/Guardian
- ❑ Partner/Spouse
- ❑ PCP/Physician
- ❑ Psychiatrist
- ❑ Teacher
- ❑ Other: _____

**Progress/Revisions:**

_____

_____

_____

***Client Signature*** **Date**

_____

***Therapist Signature*** **Date**

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

# PROFESSIONAL DISCLOSURE STATEMENT

**My Philosophy and Approach:** I believe that everyone has strengths and abilities that make us each special and resilient. A positive environment and nurturing relationships are ideal conditions to grow and heal. My goal is to tend to each of my client's needs with holistic and nurturing attention while providing a safe, confidential space for important transformations to develop. My approach is client-centered and strengths-based. I work with the individual, couple and/or family to incorporate attainable and realistic goals and often use art therapy interventions as an avenue for expression and exploration.

**My Credentials and Training:** My undergraduate training was from Gonzaga University and I hold BAs in psychology and art. I have also earned a MA in Art Therapy & Counseling (ATR) from Marylhurst University. I am trained to utilize both Art and Talk Therapy. Major areas of study included human development, ethics, assessment and treatment, the counseling process, family therapy and the uses of art in the therapy process and addiction counseling. I have earned my License as a Professional Counselor (LPC) and I constantly attend trainings and workshops to maintain current knowledge of issues, research, ethics and helpful approaches in my field. My continued studies have had a significant focus on attachment, trauma and relationships. I also participate in clinical supervision and consultation monthly. I commit to attending and learning more about interpersonal neurobiology, mindfulness practices and the enneagram. I believe that everyone has the strengths and abilities necessary to achieve resilience and that a positive environment and nurturing relationships are ideal conditions to grow and heal.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists,
I will abide by its **Code of Ethics**. In case any ethical concerns or questions arise, please feel free to ask me directly. You may also always contact the Oregon Board of Licensed Professional Counselors at 3218 Pringle Rd SE, #250 Salem, OR 97302-6312. Telephone: (503) 378-5499. Email: lpct.board@mhra.oregon.gov

**Art Therapy:** Art Therapy is more than simply doing art; however, doing art is healing in and of itself. Art Therapy is a process. Exploring with and manipulating art materials allows us to gain insight into our own thoughts and feelings. Often how one interacts with the materials might reflect similar patterns present when interacting with life and within relationships. Exploring through art provides an opportunity to process, organize and reshape feelings and thoughts. It is from these expressions we can work together to find the underlying needs.

**Payment for Services:** The initial phone consultation is FREE! The fee for individual sessions is $130 and for couples or family therapy, the fee is $150. I am in network with a few Insurance companies and out-of-network for most, so I offer direct fee-for-service and I accept payments in credit/debit cards, cash or check. I do offer sliding scale fees depending on availability and on your financial situation and comfort.

**Appointments:** The usual session time is 50 minutes. In the event of late arrival, the session will still end at the regular time and you will be charged for the full session fee. If you are going to be unable to keep an appointment, please contact me at least 24hours ahead of time. Without notice, and with the exception of a medical emergency, you will be charged for your session (full) fee for the missed appointment. Cancellation less than 24 hours will result in a $50 late cancellation fee.

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

# FEE AGREEMENT

*By signing the form below, you state your understanding of the following information:*

My goal is to make counseling accessible for anyone who feels they would benefit.

° My standard fee for individuals paying by cash or check is $150 - $120 for a 50-minute session. If a different fee is needed, Client and Therapist will agree on that fee and identify below.

° Services are paid privately by cash, check or card at the time of the session.

° If you are utilizing your insurance benefits, but have not yet made your deductible, my standard rate will be charged until your deductible is met. At that point, we will work with the contracted rate and copayments outlined by your specific benefit.

° The fees associated with counseling are your responsibility.

° Refunds are not available.

° If unable to make an appointment, 24-hour notice is required. If 24-hour notice is not given, a $50 Session Fee charge will be assessed.

° If client does not show for an appointment, the Full Fee will be assessed.

° Services may be terminated at any time, for any reason by either client or therapist.

° I may refer you to another provider - it is your responsibility to arrange an appointment with that provider.

**Fee for Services as agreed by clinician and client: _____ per 50-minute session**

*I understand the above guidelines and agree to the above per session fee:*

Client: _____ Date: _____

Guardian/Parent (if under 18): _____ Date:_____

Therapist: _____ Date: _____

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

## CONFIDENTIALITY AND CONSENT FOR TREATMENT

Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent and.or knowledge. 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 a licensee has met the minimal qualifications of training and experience required by state law.
*To examine public records maintained by the Board and to have the Board 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 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;**

*To be free from being the object of discrimination on the basis of race, Religion, gender, or other unlawful categories while receiving services.

**Emergency Procedures:** In the event of an emergency, first call the Multnomah Co. Crisis Line at (503) 988-4888 or 911 if there is immediate danger or threat. Then, my direct number is (503) 502-8593 and I check messages from 8am to 7pm on weekdays and once a day on weekends and holidays. If unable to reach me, the county, OR a crisis response worker, and your conditions progress- please go to your nearest hospital or emergency room.

### 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 receive Mental Health Services and/or Chemical Dependency Services to be provided by Christina Zimmerman, MA, ATR, LPC

Client_____ date_____

Parent or Guardian (if minor) _____ date_____

_____ date _____
(witness) *Chrissy Zimmerman, MA, ATR, LPC*

Chrissy Zimmerman Counseling
cell: 503-502-8593 email: Chrissy.Zimmerman.LPC@gmail.com
1125 SE Division St. #207. Portland, OR 97202

# FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential mental health information can be released to and/or discussed with the people or agencies listed below unless there are any noted exclusions or limitations. This form is signed voluntarily and you may make changes at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

**I, _____, specifically authorize the release/exchange/receipt of the following**
*First Name* *Last Name*

**(Client must initial each item):**

___ A&D treatment records (If initialed, specific consent below must be signed)
___ Identifying Information ___ Mental Health treatment records
___ Lab Reports ___ Psychiatric Evaluation(s)
___ Discharge Summary ___ Progress Notes
___ Consultation(s) ___ Other_____

**This information will be shared between Chrissy Zimmerman, MA, ATR, LPC and:**
Name: _____Address:_____
Phone #: _____Fax #: _____ City/State: _____ Zip: _____

**The purpose(s) for this disclosure of information is**
___ Diagnosis and Evaluation ___ Referral/Consultation
___ Treatment Planning ___ Coordinate Aftercare/Continuation of Care
___ Parent/Partner Consult ___ Other _____

**Exclusions or Limitations to what information will be shared is listed here: _____**

By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my authorization to **Chrissy Zimmerman** to disclose my records. I also understand that I may revoke this Authorization at any time by providing a written notice.

**Please refer to the Notice of *Health Information Privacy Practices* for more detailed information. This consent form will expire one year following the date signed unless revoked by you in writing or upon the happening of an event or condition as listed on the following date: _____**

| **Signature of Client:** _____ | **Date:** _____ |
|---|---|
| Signature of Authorized Representative (State relationship to patient/client) or Witness _____ | Date: _____ |

**Witness: _____Date: __/__/__ Client Copy Received:** ___Yes
___ Declined copy