Please print, review and sign, and bring to first session

High Country Counseling

Joan Zimmerman, LMFT, LCAS
Professional Disclosure Statement
(Information and Consent for Treatment)

Welcome. I am giving you the following information to insure that you have the information you need to make an informed decision regarding therapy.

I am a licensed Marriage and Family Therapist, and a licensed Clinical Addictions Specialist. I also am an AAMFT Approved Supervisor. I graduated from ASU in 2003, with a master's degree in Marriage and Family Therapy, and an Expressive Arts Therapy Certificate. I completed my LCAS in 2006.

My approach to therapy is based on a systemic perspective. I am interested in working with individuals (adults, adolescents and children), couples and families. Theoretically, I apply a variety of treatment strategies that will best fit the client's need. These theoretical orientations often include family of origin work, structural strategies, and a client-based approach. I often use experiential approaches to therapy, and expressive arts in my work. Since I believe that we each contain what we need to heal ourselves, I will usually not give you answers, but rather encourage you to come to your own truths.

During the therapy process, we will work together to identify and work on issues that are important to you. Together, we will set goals for your work, and will periodically review your goals, and assess your progress.

It is important to understand that there are potential risks, as well as benefits, of therapy. You may find that change is sometimes smooth and easy, and at other times much more difficult and slow-coming. During the process of therapy, you may deal with difficult emotional issues which may, at times, lead to unanticipated emotional stress, as well as emotional improvement. There is no guarantee of particular results or outcome from the therapy process. Of course, you are free to discontinue therapy at any time.

My cell phone number is 828/964-9211, and I try to be available in emergencies. Should you require such service and not be able to reach me, please call the local police or sheriff, medical emergency service, or other appropriate agency. Dialing 911 will connect you with emergency services.

My privacy policies are described in my Privacy Policy. In addition, it is important that you understand that when your therapy involves members of your family or significant others, all information may not be kept confidential among your client unit. It is your responsibility to be aware of what information may be shared with the other people involved in your therapy, such as your spouse. Information regarding affairs is one example. When in doubt, please ask me.

I appreciate payment after each session, unless other arrangements are made. My fees and policies regarding insurance and cancellations are attached. Policies regarding privacy and confidentiality are also explained separately.

Please feel free to ask questions about this statement at any time. By signing below, you are acknowledging that you have read, you understand and accept the terms of this disclosure statement, and that you are consenting to treatment. I will keep one copy for my confidential files, and give you a copy for your records.

Therapist's Signature _____ Date_____

Client's Signature _____ Date_____

589 W. King St. • P.O. Box 622 • Boone, NC 28607 • (828) 449-8049 • fax (828) 449-8047
www.highcountrycounseling.org

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Client Contact Information

Client's Full Name:_____ SS#_____

Date of Birth:_____ Age:_____

Address:_____

City, State, Zip _____

Emergency contact:
Name_____
Phone #:_____ Relationship:_____

Where do you work?_____

Who referred you?_____

Names, relationship and ages of all people living with you:
_____
_____
_____

Cell #: _____
Please sign here if we have your permission to call you on your cell phone:
_____

Work Phone #: _____
Please sign here if we have your permission to call you at work:
_____

Email address(es): _____
_____

Please sign here if we have your permission to send you /client email:
_____

[**PLEASE LET US KNOW IF THERE ARE ANY LIMITATIONS FOR ANY MEANS OF CONTACTING YOU – E.G., IS IT OK TO LEAVE A MESSAGE ON A MACHINE OR WITH A PERSON OTHER THAN YOU WHO ANSWERS YOUR PHONE.]**
_____
_____
_____
_____

Please be aware that all efforts will be made to maintain your confidentiality when communicating with you. However, cell phones and email may not be guaranteed for confidentiality. Therefore, please use discretion when communicating sensitive information to us. Thank you.
Please inform us of any changes in your contact information. Thank you.

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Appointment Cancellation, Payment and Insurance Policies

1. **Appointment Cancellation**
   An important part of the therapy process is accepting responsibility for making and keeping appointments. I make every effort to provide you with your chosen appointment time, and set that time aside for your consultation. I understand that there are times when cancellation is unavoidable, but I reserve the right to charge for "no show" appointments, and appointments canceled with less than 24 hours notice.

2. **Payment**
   I appreciate your payment at the end of each therapy session, unless we have made other arrangements. My fee is $120.00 per hour.

3. **Insurance**
   I accept BCBS insurance. In other cases, I will provide you with a detailed receipt that you can use to file with your insurance company. Since insurance coverage varies from company to company, your treatment may not be covered. I encourage you to insist upon reasonable coverage from your company, and will be happy to provide you with whatever information you request. I am dedicated to protect your confidentiality and your privacy, and therefore, will not answer questions from insurance claims representatives without your written permission.

I have read and understand the above written Appointment Cancellation, Payment and Insurance Policies and/or have had them explained to me. By signing and dating below, I am agreeing that I will comply with the policies.

Client Signature: _____ Date:_____

Therapist Signature: _____ Date:_____

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Notice to Persons Regarding My Privacy Practices

During this initial contact with you, we discussed confidentiality and privacy issues. These practices are designed to protect your individual identifiable information and confidentiality. Although we are legally required to tell you about our privacy practices, we also believe that telling you about confidentiality is the right thing to do.

Although we have discussed our privacy and confidentiality practices with you, we will give you a written copy of our *Notice of Privacy Practices* if you request. The written *Notice of Privacy Practices* outlines how we can use and disclose information along with the rights that you have regarding your information maintained by us.

Also, we must obtain written acknowledgement that we have discussed our privacy practices with you. By signing this form, you are only acknowledging that you have been informed about out practices to maintain privacy and confidentiality. Please indicate if you want a copy of the *Notice of Privacy Practices*.

Finally, if you have any questions about your privacy at our practice, please contact Joan Zimmerman.

If you believe your rights have been violated or have a complaint about our practice, you may contact Joan Zimmerman or the Secretary, Department of Health and Human Services.

By signing this document I am acknowledging that I have

___ been informed about how my privacy and confidentiality will be maintained by Joan Zimmerman.

___ requested and received a copy of Joan Zimmerman's *Notice of Privacy Practices*

_____ _____
Client Signature Date

_____
Relationship to Client

_____
Person Providing Notice