La Perla Counseling and Trauma Response Services, Inc.
Kristine Zimmerman, MA, LMHC, CSAT, CMAT
1611-116th Ave N.E. Suite 215, Bellevue, WA, 98004
425-449-8171 | 425-478-6010

Client Registration
(Please Print)

Name (including prefix):_____ Today's Date: __/__/____
Address: _____

_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____
Email:_____
Birthdate: __/__/____ Age:____ Marital Status: __Single __Married __Separated __Divorced
Spouse's name (if married): _____
Social Security Number: _____ Driver's License Number: _____
Emergency Contact:_____ Relationship to Client:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Client's Employer: _____
Occupation: _____ Date Hired: ____/__/____
Referred By (if applicable): _____

Person Responsible For Bill, If Not Client

Name (including prefix):_____ Today's Date: __/__/____
Relationship to client: __Spouse __Child __Dependent __Other:_____
Address: _____

_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

PLEASE NOTE: Claims submitted to Insurance are subject to individual plan provisions and are not a guarantee of payment. **The provider is not responsible for any unpaid claims; please check with your Insurance Company to receive full benefits*

PRIOR TO CLAIMS BEING PAID YOUR INSURANCE POLICY MAY REQUIRE ONE OR MORE OF THE FOLLOWING FROM YOU:

- **Obtain preauthorization prior to your first appointment**
- **See a contracted plan provider**
- **A written referral through your primary care physician**

Full fees charged for sessions cancelled with less than 48-hour notice.

By signing below I fully understand the above stated information, and I am responsible for my total fees at the time of service and I may seek insurance coverage with this provider on my own.

Signed: _____**Today's Date**: __/__/____

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Personal Data

Name: _____ Birthdate: ___/___/____ Age:_____
Parents' Names:_____
Siblings' Names:_____
Spouse (or Significant Other):_____
Children:_____
Support Person:_____
Hobbies/Interests:_____
_____
Losses:_____

Reason For Visit: (please circle) Addiction Depression Traumatic Event Co Dependency Life Changes
Other:_____
Are you involved in a 12-step program or Support Group of some kind? Yes No
What kind of Counseling do you prefer? (please circle) Traditional Christ Centered
Do you have a religious preference? _____
Place of Worship: _____

Current Medications (including dosage): _____
_____

Pertinent Medical History: _____
_____
_____

Do you use any of the following? If so, how often? (please circle)
Coffee: Yes No *Frequency: Daily Weekly Monthly Yearly Never* Number of cups per day: _____
Tea: Yes No *Frequency: Daily Weekly Monthly Yearly Never* Number of cups per day: _____
Alcohol: Yes No *Frequency: Daily Weekly Monthly Yearly Never*
Number of drinks at each sitting: _____
Marijuana: Yes No *Frequency:*_____ **Tobacco**: Yes No *Frequency:*_____
Other:_____

Person Referred By:_____

Goals for Treatment/Visit Today: _____
_____
_____

Why Now?_____

_____

Current or Past Treatment Information: _____

_____

_____

Have you ever received Psychological Counseling or Psychiatric Counseling before? Yes No

Counselor or Doctor's Name(s) and Place(s) of Practice: _____

_____

Please describe the main difficulty that has brought you to see me:_____

_____

_____

Indicate the severity of your problems on the scale below: (please circle)

Mild Moderate Severe Extremely Severe Incapacitating

Please indicate the major stressors in your life in the last twelve months: (please circle)

Serious Injury/Illness Death of a close friend or Relative Major Illness in Family

Divorce/Separation Job Change Gain of New Family Member

Other (please describe):_____

_____

Please describe what you would like to be different in our life when you are done with therapy: _____

_____

_____

Have you ever thought about suicide? Yes No

Have you ever attempted suicide? Yes No If Yes, when?_____

Have you ever had a traumatic brain injury? Yes No If Yes, when?_____

Have you ever been involved in an accident where your head was hit? Yes No

(For example: Diving into a pool, car accident where your head hits the windshield, falling off a horse)

If Yes, when?_____

Are you required by a court, the police, or a probation officer to have this appointment? Yes No

If yes, please explain:_____

_____

Is there anything else that is important for me, as your therapist, to know about that you have not written on any of these forms? If yes, please explain here or on another sheet of paper:_____

_____

_____

Client Signature:_____ **Date:**___/___/_____

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Campus Office Park 1611-116th Ave N.E. Suite 215
Bellevue, WA, 98004
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office@laperlacounseling.com www.laperlacounseling.com

DISCLOSURE

Before starting any counseling, the State of Washington requires specific information be provided for you regarding services rendered by a mental health care provider. This statement of disclosure is to inform you of your rights, responsibilities and the provisions of state law. It also is designed to offer you some background information about your therapist, inform you of their clinical interests, expertise, fees, and therapeutic approach.

As you are considering the beginning of a relationship with a counselor, it is important that it be a helpful, rewarding, and healing experience. Kristine believes that choosing a mental health counselor must be both an intuitive and informed decision. Normally she allows one to three sessions to evaluate whether the relationship will be a mutually good fit. However, before this occurs, there should be a shared understanding of what to expect.

Please take the time to read this disclosure carefully to make sure all the information is clear. If you have any doubts or concerns after reading this document, please feel free to ask any questions.

INFORMATION ABOUT KRISTINE ZIMMERMAN

I am a licensed mental health counselor. I received my Masters Degree from City University in 2001, and my Bachelors degree from the University of Washington School of Social Work in 1997. I worked for twelve years at The Bastyr University Counseling and Wellness Center. I am trained as a Certified Sex Addiction Therapist, under the study of Dr. Patrick Carnes, through the International Institute For Trauma & Addiction Professionals (IITAP). I am also trained in the PIT model, developed by Pia Mellody, for the treatment of codependence. I have been in private practice since 2002.

THERAPEUTIC ORIENTATION

I have a general practice with an emphasis on sexuality, relationships and related mental health issues. I use a psychodynamic approach to therapy with attention to how unresolved problems from the past, as well as current behavior patterns or habits can cause present day stress and conflict. The techniques vary depending on your specific needs. I use study materials that employ a Task Centered Approach where needed.

Therapy is meant to create positive change in your perceptions and feelings about yourself and your life. The therapeutic relationship requires trust, openness and commitment to change. It often brings up a variety of intense feelings and can be emotionally stressful, possible leading to an increase in symptoms, making you feel worse for a period of time. This can be a normal part

of the process and is important to understand before you begin. Please ask me for clarification if you have questions regarding this.

SCHEDULING & STATEMENT OF TREATMENT

If you would like to schedule an appointment, you may call the office at 425-449-8171, or email office@laperlacounseling.com. Office hours are Monday through Friday by appointment. Phone calls are typically returned within 24-48 hours during business operations. Kristine does not use text messages to communicate with clients as confidentiality cannot be guaranteed.

If group therapy is a part of your treatment plan, this document is provided as a disclosure, and payment is required for each of the 12 weeks, regardless of attendance.

Kristine endeavors to provide the highest quality of counseling possible by working with her clients to create treatment plans that are effective and beneficial. Please discuss directly with Kristine if you believe you need another counselor or a different therapeutic approach. It is understood that if you choose to exercise your right and privilege to seek counseling elsewhere, your decision will be respected.

FEES

A portion of each therapy session fee will go to La Perla Counseling & Trauma Response Services, Inc. for office and administration costs.

Intake Fee

Initial visits are called intakes. It is important to gather historical information so the first session time will be one hour long. Initial intakes, therefore, have a one-time charge of $165.00 and they are 60 minutes in length.

Standard Fees

The fee for a standard 45 minute counseling session in the office is $140.00. An extended 60 minute session is $165.00, and a 75-90 minute double session is $280.00. **Payment at time of service is required**. If you believe full payment at the time of service places you in a hardship situation, please discuss with Kristine to see what payment schedule might work for you.

Groups

Fees for groups are $50.00 per person, per week, and require a 12 week commitment, per disclosed, ***regardless of attendance.*** Attendance is not required but is expected, and you will be charged even if you are not present in group.

Electronic Communication

Due to the preservation of confidentiality and the sensitivity of information discussed in therapy, Kristine does not provide counseling through email, however emails can be used for scheduling purposes. La Perla Counseling and Kristine Zimmerman will do everything in their power to protect privacy according to HIPPA standards of confidentiality. For further information on electronic based interaction please see policy below pertaining to social media.

Telephone Conversations/Email

Under special circumstances Kristine may agree to a session over the telephone in place of a face-to-face session. Please talk with her directly to determine if this exception is warranted. During regular business hours (Monday through Friday, 10:00am-7pm) these sessions will be billed identically to an in-person session; $140.00 for 45 minutes, $165.00 for 60 minutes, and $280 for 75-90 minutes. Consultations outside these hours will be considered emergency hours and will be billed at $280.00 per hour. **In case of an emergency, or when Kristine is not otherwise available, please call the crisis line at 206-461-3222 or dial 911**.

There will be a charge for telephone consultations with other professionals (including attorneys and mental health care providers), especially those which arise out of legal matters that are a party to a client case. These will be pro-rated based on the length of the call. If there are multiple calls, which collectively last longer than 10 minutes, they will be put together and charged to your account as appropriate.

Facetime and Skype

Under special circumstances Kristine may agree to use Facetime or Skype in place of a face-to-face session. Please talk with her directly to determine if this exception is warranted. Facetime and Skype are currently considered Telemedicine and may not fully be covered by insurance companies. Please inquire with your provider whether or not reimbursement is available. Facetime and Skype sessions are billed at the rate of $140.00 for a 45 minute session, $165.00 for a 60 minute session, and $280.00 for an extended 75-90 minute session.

PAYMENT & INSURANCE COVERAGE

Fees for services are required at the time of your appointment and may be made by check, cash, money orders, Visa, Mastercard, Debit Cards and/or leaving an approved card number on file. Please make arrangements to have payment for your appointment at time of service.

If you wish, please inquire with your insurance company whether they cover Licensed Mental Health Counselors (LMHC), or Professionally Licensed Counselors prior to your appointment. You can ask whether they cover "out of network providers", and if so, what the coverage is. Many insurance companies do not volunteer this information unless specifically asked. Others require that you obtain a referral from your medical doctor.

If you elect to use your insurance benefits, you may ask for a receipt and diagnosis code from Kristine so you can submit them to your insurance company for any appropriate reimbursements.

MISSED APPOINTMENTS/IMPROPER CANCELLATIONS/COLLECTIONS

A 24-hour notice is required for cancelations of appointments. The established fee will be charged for an appointment which is missed or where notification is not received 24 business hours in advance of the designated appointment time. Insurance will not cover missed appointments, no-shows, or improper cancellations. Let us work together on this to make sure it doesn't happen. Please give Kristine as much notice as possible since your missed appointment time may provide time for someone else who also has a need for counseling. Thank you in advance for your courtesy in this area.

Last minute sick calls (less than the 24 hour notice of cancellation) will be billed as a courtesy at a half-rate. Cancellations made over the weekend for a Monday appointment time will be considered a short cancellation and will incur a fee. Please ensure your request for cancellation or rescheduling is submitted 24 business hours before you appointment time. For example, if an appointment has been made for Monday afternoon at 2pm, a call to cancel would need to be placed before or at 2pm the preceding Friday.

Dropped or missed calls or messages due to cell phone use are not the responsibility of the therapist. Please consider the use of a land line for contact when in doubt, otherwise, you will be charged full fee for a missed session if no timely message has been received.

If an account becomes delinquent and client efforts are not made to make the account whole, Kristine reserves the right to exercise whatever means available under the law to receive payment on the account, up to, and including, collection services.

TERMINATION OF TREATMENT

If you decide you would like to discontinue therapy for any reason, it is requested that you please terminate treatment by discussing it with Kristine (in advance). If your needs are not being met she may be able to provide you with a referral, or, if appropriate, discuss with you what defenses you may be experiencing (which may be interfering with your healing process) and how it can be useful to the therapeutic process. You may, of course, terminate treatment at any time for any reason.

Any veiled threats of acting out violence in the office or violent outbursts will result in immediate termination of therapy and a referral to another practitioner.

SOCIAL MEDIA & ELECTRONIC COMMUNICATION POLICY

Friending

Kristine Zimmerman and La Perla Counseling does not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Shqe believes that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions about this, please bring them up in session and talk directly with Kristine.

Interacting

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact Kristine or La Perla Counseling. Confidentiality on these sites is not ensured and the messages will likely not be read. The use of Wall postings, @replies, or other means of engaging with her in public online will not be acknowledged. Engaging this way could compromise confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you do need to contact Kristine between sessions the best way to do so is to call the main office at 425-449-8171, or email at office@laperlacounseling.com.

STATEMENT OF CONFIDENTIALITY

All the information revealed in session to a therapist or counselor is confidential and will not be disclosed without the client's written release. Exceptions to this policy are when the laws of Washington State *require* health care professionals to reveal information to others with or without the client's permission. The following situations describe when the exceptions occur:

a) If a client intends grave bodily harm to another person.
b) If a client intends grave bodily harm to him/her self.
c) If a court of law issues a court order to reveal information.
d) If a situation of current child abuse, elderly abuse, or abuse to a developmentally disabled person is revealed.

A Health Care provider may disclose that health care information about a patient without the patient's authorization to the extent a recipient needs to know the information if the disclosure is to:

a) A person who the provider reasonably believes is providing health care To the patient; or
b) If the therapist has a *duty to warn* someone specific in accordance with the law (refer to 1-3, below).

There are some circumstances in which people may obtain your records. If you do not wish to have disclosed under any circumstances, you need to sign a form stating you do not wish to have your health care information disclosed without written consent. Please refer to the "Informed Consent" form accompanying this intake packet.

DUTY TO WARN OR REPORT

Washington State law requires counselors to report instances of abuse and we may be required to report harmful, dangerous or criminal action against intended another human being or oneself. In these cases, it is the therapist's legal duty to warn specific individuals of such intentions. For example:

l. A family member of the client who is likely to suffer grave personal harm.
2. A family member of the client who intends to harm themselves or someone else.
3. Law enforcement officials, hospitals, or child protective services.

Before informing anyone who may need to be warned or making any reports, I will first take steps to share that intention with you (if you are the client).

No child under the age of 18 may be left unattended in the building due to the need for child protection and safety. Other therapists in the building may be seeing high risk, court ordered clients. If you have a child under the age of 18, you must provide appropriate supervision and safeguarding while you are in your counseling session.

Adolescents in this state who are of the age of 13 or higher may have specific rights to confidentiality with their therapist. Parents bringing their children in for counseling please take note and be apprised of your children's legal rights to confidentiality. Please feel free to direct your questions or concerns to the counselor.

DISCLOSURE OR RELEASE OF INFORMATION

If you are a minor (under 18 years old) and the victim of a crime, your therapist may be required by law to testify at an inquiry concerning that crime. Also, some of the information you give may be discussed with your parent or guardian.

Under certain circumstances, whether you are a minor or an adult, information that you reveal might be subpoenaed. A court of law would determine what information, if any may be revealed. In a case where collection services are needed, information will be provided to obtain appropriate payment for services that have been rendered. If you wish certain information to be disclosed or released to a third party (another counselor, physician, or social worker, for example), you will need to sign a written consent.

CONSULTATIONS

For the purpose of consultation, your case may be discussed with a certified mental health professional, an M.D., or a licensed supervisory consultant whose services are solely for professional consultation. Names are not included when discussing cases to ensure anonymity.

INFORMATION PRACTICES

Health care providers are required to provide you with the following information:

A record of the services provided you are kept at this site and you may ask for a copy of that record. You may also ask the record to be corrected. The record will not be disclosed to others unless you direct me to do so or unless the law authorizes and compels me to do so. You may see your record or get more information about it from Kristine. Your records will be kept for seven (7) years. After seven years they may be destroyed through a disposal service which maintains confidentiality.

REQUIRED DISCLOSURE INFORMATION

Washington State law requires the following quote to be included in disclosure statements: "Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment" WAC 246-810-031(i).

The purpose of the Counselor Credentialing Act is to provide a law of protection for public health and safety; and to empower citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. WAC 246-810-031(j)

A list of acts can be provided for you, which are deemed as "acts of unprofessional conduct" by a counselor. WAC 246-810-031(m)

PERSONS TO NOTIFY OF CONCERNS ABOUT YOUR THERAPIST:

Kristine Zimmerman, MA, LMHC, CSAT, CMAT ,
1611--116th Ave. N. E. #215
Bellevue, WA. 98004
425-449-8171
UBI#
License # LH 00010804

Dept. of Licensing
Business & Professional Admin.
P. O. Box 9034
Olympia, WA. 98504-8001
Phone 360-664-0116

I understand attached disclosure statement and I have read and agreed with the statements above. My signature confirms I understand the above disclosure, directions, and I have received a copy of the following items:

(Please do not sign this until we agree everything has been covered and all your questions have been answered)

I have received a copy of the:

1. Disclosure statement (this document)
2. Statement of Treatment (included in this disclosure)
3. Confidentiality Limitations (included in this disclosure)
4. Financial Policy (included in this disclosure)
5. Informed Consent (included in packet)
6. Implications of mental health diagnosis and insurance benefits paying for my therapy or family members (included in packet - one sheet)
7. Washington State Brochure entitled *Counseling or Hypnotherapy Clients* (handout - I do not provide hypnotherapy)
8. Authorization of Healthcare Release (included in packet)

_____Client _____Date

_____Therapist _____Date

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Therapy Contract/Informed Consent

Client: _____ Date: _____

Home Phone: _____ Work/Cell Phone: _____

Date First Seen: _____ Referred By: _____

Check this area if you do not wish to have progress notes kept on your case:_____

Kristine Zimmerman, MA, LMHC, CSAT, CMAT , has agreed to provide an outpatient treatment in the following manner:

Frequency:	**Fee**
Individual therapy:	**$**
Conjoint/Family therapy:	**$**
Group therapy:	**$**
Estimated Length of Treatment:	
Goal of Treatment:	
Travel time:	**same as hourly fee door to door**

I have read the treatment plan indicated above. This treatment plan reflects Mrs. Zimmerman's professional opinion and my stated personal preference. I understand this treatment plan can be modified by me, in consultation with Mrs. Zimmerman, at a later date. I understand that Mrs. Zimmerman is a Licensed Marriage and Family Therapist. I also understand that Mrs. Zimmerman's fee is $140 for a 45 minute session and $165 for a 60 minute session. I understand Mrs. Zimmerman consults with a professional case consultation group where my case may be discussed from time to time to ensure the best application of treatment planning is made available for my care.

Please ask for clarification if you are unsure how the work we are doing pertains to your reason for seeking therapy. This meets the disclosure requirements as set by the Health Department for the State of Washington.

Client: _____ **Date:** _____

Therapist: _____ **Date:** _____

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Communication Agreement

Name: _____ Birthdate: ___/___/_____

Your Healthcare Provider may need to contact you to discuss your health, review results of testing, or to coordinate your care. Please review and answer the questions below outlining your preferences regarding this communication. *Additional phone numbers can be listed below.*

1. May we leave messages regarding your health information on your answering machine or voicemail at home?
   _____NO ____YES ____N/A

2. May we discuss your medical care with anyone that answers the telephone at your home?
   _____NO ____YES ____N/A

3. May we leave messages regarding your health information on your answering machine or voicemail at work?
   _____NO ____YES ____N/A

4. May we leave messages regarding your health information on your cell phone voicemail?
   _____NO ____YES ____N/A

5. Are there members of your family, household, or those coming with you to this appointment with which we should not discuss any of your health care issues?
   _____NO ____YES ____N/A

   If yes, please explain:_____
   _____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be canceled or modified. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

_____ _____
Patient or legally authorized individual signature **Date**

_____ _____
Printed name if signed on behalf of the patient **Relationship**

Home Phone:_____ Cell Phone: _____ Work Phone: _____

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Authorization for Use and Disclosure of Protected Health Information

For Purposes Requested by ☐ Provider or ☐ Patient

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

Name of Provider/Recipient of Information: _____

Address: _____

_____

Phone:_____ Fax:_____ Email:_____

Age:_____ D.O.B.:_____ Attorney:_____

Check one: ___ Insurance ___ Other:_____ Deliver copies by: ☐ Mail ☐ Email ☐ Fax

For the following purposes:_____

_____

Types of Information to be Disclosed:

☐ Entire Medical Record ☐ Office Chart Notes ☐ Discharge Summary ☐ All Hospital Records
☐ Emergency and Urgent Care Records ☐ Medical Records for Continuity of Care ☐ Police Reports
☐ Substance Abuse Treatment Reports ☐ Teacher Reports ☐ Guardian Ad Lietem Reports

Extent of Information:

I am aware that these records may contain information concerning the testing, diagnosis, and treatment for HIV/AIDS, other sexually transmitted diseases, and/or substance abuse services governed by 43 CFR Part 2, and/or mental health services governed by RCW 71.

Revocation:

It is my understanding that this authorization can be revoked at any time, except to the extent that use and/or disclosure made in good faith may have already occurred in reliance on this authorization.
Revocation Date:_____ *Re-disclosure Date*: _____

Expiration:

If not previously revoked, this authorization will expire 180 days from the date of signing or (date):_____
(*Specific limitation*: Except as to third-party payers, this authorization does not include disclosure for health care services received more than ninety (90) days from the date of last signature.)

Signature:

My signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment, or eligibility for benefits.

Initial Signature:_____ **Date:**_____

Printed Name of Patient's Representative (If applicable):_____

Witness:_____

Renewal Signature:_____ **Date:**_____

Printed Name of Patient's Representative (If applicable):_____

☐ **Sonja Rudie, MA, LMHC, CSAT, C-EMDR** ☐ **Blair Schmautz, MA, LMHC, CSAT**
☐ **Steve Sandvik, MA, LMHC** ☐ **Kerry Fitzgibbons, MA, LMFT, CEAP**
☐ **Danielle Melton, MA, LMHC, NCC** ☐ **Kristine Zimmerman, MA, LMHC, CSAT, CMAT**

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Insurance Benefits

Most Health insurance companies now include some form of mental health care coverage. If you have mental health insurance, there are certain issues I believe are important for you to consider.

Medical Necessity

Most people with health insurance assume they can just use their mental health benefits on the basis of their desire to participate in counseling or psychotherapy, or with a letter of referral from their doctor. The reality is that insurance companies require that mental health care treatment be considered "medically necessary". To be considered medically necessary, the treatment must address a mental disorder. Counseling or psychotherapy intended solely for self-improvement or normal life stress reactions is not considered medically necessary by insurance companies, and therefore, not covered by insurance mental health benefits.

A Mental Health Diagnosis

Medical necessity can be established when an individual describes certain psychiatric symptoms and/or behavior that affects their ability to function on the job, school, or relationships. For example, someone might begin therapy because they are feeling depressed and are having trouble feeling motivated to complete tasks, visit with friends, and/or are having trouble sleeping.

When someone begins therapy and describes such symptoms, their insurance company requires that the therapist assign them a mental health diagnosis. You should know that all diagnoses have certain actuarial ramifications, as do smoking, age, weight, sex, and other past medical conditions. You should also realize that if you are ever asked whether you have been treated for a psychiatric problem you will have to answer "yes" because your permanent medical records will contain this information.

Confidentiality and Privacy

When you submit a claim to your insurance company for reimbursements for treatment, you are required to sign a release form in which you are giving your insurance company the right to ask for whatever documentation and information it deems necessary to determine the legitimacy of the claim.