Professional Disclosure Statement
Sisu Counseling Services

Tina Lips, MA
503.317.8913
8305 SE Monterey Ste. 220
Portland, OR 97086

Approach
Counseling is a collaborative process between you and I. This is a personal and safe process that deeply respects and honors each individual's unique humanity. My approach to therapy focuses on the whole person influenced by physiology, socio-political influences, family, community, and spirituality. We will explore how your social context and community affects your view of self. We will explore intrapersonal elements such as, authenticity, responsibility, meaning and purpose. After a few sessions we will collaborate on therapy goals that you and I agree upon.

It is important for you to understand that the counseling relationship is a professional one. This is not a friendship and if we encounter one another in public I will not acknowledge you in order to protect your confidentiality and privacy rights. If you choose to greet me I will respond in kind but will not disclose myself as your therapist.

As a member of the American Counseling Association I adhere to, and will abide, by their Codes of Ethics. I will adhere to the Oregon Licensing Board's Code of Ethics set forth in OAR Chapter 833, Division 60;

Education and Training
I hold a Master of Arts in counseling from Western Seminary. I have been trained in and studied the areas of human development, sexual issues, multi-cultural counseling, group counseling, suicide prevention, parenting, play therapy, adolescent counseling and couples counseling.

Supervision and Consultation
As a registered intern in the State of Oregon, my counseling practice is under approved clinical supervision by Terry McGlasson, LPC, NCC. Your specific identifying information is not disclosed to anyone other than my supervisor, Terry McGlasson, LPC, NCC.

Fee Schedule
The fee for counseling is $80 for every 50 minute session. You will be charged the full fee if less than 24 hrs. notice is given for non-emergency cancellations. You will be responsible for all returned check fees incurred.

(turn over)

Client Bill of Rights

The following sets forth your rights as a counselee under the Code of Ethics of the Oregon Board of Licensed Professional Counselors and Therapists, *(ORR 833-60-004(h)).* Consumers of counseling or therapy services offered by a professional counselor have a right to:

a. To expect that the counselor has met minimal qualifications of training and experience required by state law.
b. To examine public records maintained by the Board and to have the Board confirm credentials of a counselor.
c. Obtain a copy of the Code of Ethics.
d. Report complaints to the Board of Licensed Professional Counselors and Therapists.
e. To be informed of the cost of professional services before receiving services.
f. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
    i. Reporting suspected child abuse.
    ii. Reporting imminent danger to client or others.
    iii. Reporting information required in court proceedings or by client's insurance company or other relevant agencies.
    iv. Providing information concerning the counselor's case consultation & supervision.
    v. Defending claims brought by client against counselor.
g. Be free from being the object of discrimination on the basis of race, religion, gender and any other unlawful category while receiving services.

Counseling Agreement

It is agreed that you shall make a good faith effort at personal growth and engage in the counseling process as an important priority at this time in your life. Your gain is most important in counseling. Pattern(s) of behavior that reveals disinterest or lack of commitment to counseling or any unresolved conflict or impasse between us will be addressed. Suspension, termination or referral of services shall be discussed between you and I.

If you have any questions regarding the counseling process or this disclosure statement, feel free to ask. If at any time or for any reason, you are dissatisfied with my services, please let me know. If we are unable to resolve your concerns, you may report your complaints to: Oregon Board of Licensed Professional Counselors & Therapists 3218 Pringle Rd SE #250 Salem, OR 97302-6312, (503)378-5499.

ACKNOWLEDGMENT OF RECEIPT

I, ___________________________________ have read and fully understand the information provided to me by Tina Lips, MA on pages 1-2 of her Professional Disclosure Statement. I have received the document and have detached and signed this acknowledgement.

____ _____________

Client Signature Date

____ _____________

Therapist Signature Date

Individual Questionnaire
Sisu Counseling Services

Name:____

Date of Birth:__________________ Source of Referral: _________

Are you: __single__dating__engaged__married__separated__divorced

Address: ____

Phone:______________Cell:_______________Work___________

E-mail:____

How would you prefer to be contacted?______________________

How should I identify myself?____________________________

Emergency Contact:______________________ Phone__________

Others living in the household Relationship

Reason(s) for seeking counseling:

How long have these issues been troubling you?

What are you hoping to achieve in counseling?

Please do not write in this column

File #

Date

Fee

Medical History:

Physician________________________________Phone_______________

Current medical conditions:

Current medications Dosage Reason for taking

Have you ever had a head injury? _______

Mental Health History:

Have you ever seen a therapist in the past? ________

Have you ever been hospitalized for a mental illness? _____

Have you ever attempted suicide?_____

Current mood:

Depression:

____

very depressed moderate not depressed

Anxiety:

very anxious moderate not anxious

Marital/Family History:

Marriage date(s) list divorce/separation date if applicable

Is your marriage an area of struggle or strength for you? _________

Please do not write in this column

List all children:

Name | Birth year | Biological, adopted or step

Please do not write in this column

Social History:

Do you have a close friend(s)?

How often do you get together?

Are you involved in any clubs, organizations, church, and/or groups?

Please List:

Spiritual History:

What spiritual tradition were you raised in, if any?

Do you currently practice a spiritual tradition? ________

Are your spiritual beliefs helpful or a hindrance to you? _________

Will your spiritual beliefs be an important part of counseling? _____

Education History:

How many years of school have you completed? __________

How many schools did you attend through high school? _________

What were your grades like? ________________________________

Do you have a diagnosed learning disability? ______

Employment History:

Please list your most recent jobs, including seasons in the home, most recent first:

Are you satisfied with your current employment situation?

____

Unsatisfied moderate very satisfied

Please do not write in this column

Legal History:

Are you currently involved in any legal litigation?_____

Do you have any prior convictions?________

If so, please list

Drug and Alcohol History:

Have you ever received treatment for substance abuse?_______

Have you ever used any illegal drugs?_______When __________

How much alcohol do you consume? ________________________

How many cigarettes do you smoke per day? __________________

How much caffeine do you consume per day? _________________

Has or does anyone in your family/household have a substance abuse problem? __________Who_________

Business Practices
Tina Lips
Sisu Counseling Services

Please initial each line item and sign below:

________1. Fees are due at the beginning of every session. I am unable to process credit cards at this time. Checks or cash are accepted. Checks can be made out to Tina Lips.

________2. You are responsible for all bank fees on returned checks. If 2 checks are returned unpaid, you will be required to pay in cash there after.

________3. Please call at least 1 day in advance of canceling an appointment. You will be responsible for the full fee if less than 1 day notice is given.

________4. If you are more than 15 minutes late your appointment will be cancelled for that day and you will be charged the full fee.

________5. 4 weeks of unexplained or undiscussed absences will result in the termination of our counseling relationship. You may contact me again to reinitiate counseling at a later date.

____
Client Signature Date

____
Therapist Signature Date

Consultation and Taping of Sessions
Sisu Counseling Services

In order to assure quality care I seek consultation with fellow therapists. At no time will your identifying information be given. This practice is consistent with the guidelines of the State of Oregon and the American Counseling Association.

It is very beneficial to me as a therapist to audio tape sessions. I may play these tapes for my supervisor, Terry McGlasson, LPC, NCC, colleagues that I seek consultation from and for my own review process. All audio taping is done with a digital recorder and will be deleted when therapy discontinues and often sooner.

Check one:

_____I, ____________________________, I have read the above and **agree** to allow audio taping of sessions. I understand that I may request it to be turned off at any time.

_____I, ____________________________, I have read the above and **do not agree** to allow audio taping of sessions.

____
Client Signature   Date

____
Therapist Signature   Date