



**Braeden Guter**  
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(503) 512-9545  
11105 NE 14th Street  
Vancouver, WA 98684

### **PROFESSIONAL DISCLOSURE STATEMENT FOR BRAEDEN GUTER**

This statement is supplied for your information and protection. It provides information regarding my approach to counseling, education, training and credentials, your rights as a client, and my fees.

**APPROACH TO COUNSELING:** We are all looking to feel understood, known, and supported through life's many challenges. Though we seek these characteristics in relationships throughout our life, they can sometimes grow confusing, unhealthy, and maladaptive. Counseling provides an opportunity to take risks and dig into the parts of ourselves that have been causing pain or simple talents we forgot we had. In this counseling process I will aim to assist you in discovering new parts of yourself or remembering the healthy parts that allow life to feel more manageable. This will be done by utilizing a variety of approaches that primarily center around listening and being present with the individual. It is crucial for you to play an active part in counseling, including goal setting and the overall course of the counseling process. My goal as a therapist will be to assist you in understanding yourself, your goals, and achieve an overall greater level of well being. I value the diversity and worldview of each individual, acknowledging that these aspects play a critical role in the stories and events of life.

Therapy generally consists of three, possibly four, "phases." Phase one will primarily consist of listening to and understanding the client's (or clients') current situation, problem, pain, crisis, or dilemma. Phase two focuses upon the isolation and further exploration of a particular issue (or two) that is most troubling to the client. Phase three involves defining and implementing new, or improved, patterns and ways of thinking, feeling, and/or behaving regarding that issue. Phase four is the maintenance and adjustment of those new patterns as the client works through and overcomes the potential difficulties and setbacks of living out such patterns.

Sessions between a counselor and client may be very intimate emotionally and psychologically. Client and counselor understand that the relationship will remain on a professional level rather than a personal one. Contact will be limited to the paid sessions in the office or over the phone. The client and counselor shall not engage in physical contact, socialize, give gifts to each other, nor establish any relationship other than the stated counseling relationship. Counseling sessions focus exclusively on client concerns and all interactions will be solely for the client's benefit.

I practice under the code of ethics established by the American Counseling Association and by the American Association of Christian Counselors; and by the American Counseling Association.

CLIENT RIGHTS: As a client, you are rightfully entitled

- To expect that the staff has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the State and to have the State confirm credentials of staff;
- To obtain a copy of the Code of Ethics, Oregon Revised Statutes (ORS), or Washington Administrative Code (WAC);
- To report complaints to the proper authorities (i.e. WA State Department of Health; American Counseling Association; American Association of Christian Counselors, etc.);
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving these services;
- To obtain permission to view your file, by way of written request stating reason(s) to the therapist
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the exceptions to confidentiality of information obtained in the course of services that include the following:
  - Reporting suspected abuse of a child, developmentally disabled person, or a dependent adult;
  - Reporting imminent danger to client or others, including (but not limited to) suicidal behavior or when a client is HIV positive and is unwilling to inform individuals with whom he/she is intimately involved;
  - Reporting information required in court proceedings, or by client's insurance company, or other relevant agencies;
  - Student consultation or supervision;
  - Defending claims brought by client against therapist;
  - Client has signed a release of information authorizing said disclosure.

Therapy is understood to be a choice made by the client, among available options. Options include other centers, therapies, support groups, self-help resources, and other modes of treatment. Medical treatment may also be another viable option. The client may choose not to seek treatment at this time. If therapy is chosen, client's symptoms may worsen before improving, fail to improve, or continue to worsen. Some clients need only a few sessions to achieve their goals, while others may require months or even years of counseling. The client has the right to terminate at any time; however, it is understood that premature termination may result in the return or worsening of the initial symptoms or problems.

Clients are encouraged to talk with the counselor directly if dissatisfied with the services received, desirous of a second opinion or referral, or if intending to discontinue appointments.

EDUCATION: As an Intern Counselor, I am currently working towards a Master's in Counseling degree from Western Seminary in Portland, OR. I also hold a Bachelor of Science degree in Psychology from Dixie State University.

SUPERVISION: As an Intern Counselor, I am actively being supervised by Breanna Jeffries, LMHC. As such, there may be times that Breanna Jeffries may participate in sessions directly or be involved in giving me professional direction or guidance in between sessions. Breanna Jeffries may be contacted directly at 503-928-6510.

VIDEO TAPING: For the purpose of supervisory review, I may request that a session be recorded. I will provide an additional disclosure statement consent form for your signature during intake. If this is something that you are unwilling to consent to, or otherwise feel uncomfortable with, please let me know during the intake process.

FEES: My fees for individual therapy are on a sliding scale based on your household income, at the rate of \$20 to \$50 per session. Sessions are typically 50 minutes long, with the exception of the initial “intake” appointment and some couples and family sessions, which can be up to 90 minutes long and are billed at 1.5 times the session amount. Rates and payment arrangements will be determined at the time of scheduling. Payments are due at the time of each service. Group fees are \$15-\$35 per participant, per session. Rate is determined by several factors including group size, topic, and supply needed.

CANCELLATION POLICY: Clients are expected to contact the counselor at least 24 hours in advance to cancel or reschedule an appointment. Full fees may be charged for missed sessions.

EMERGENCY SERVICES: If in need of emergency services, the client should call a crisis line in Clark County Crisis Line at 1-800-626-8137 or the National Suicide Prevention LifeLine at 1-800-273-TALK or call 911.

ACKNOWLEDGEMENT OF RECEIPT: I/We, \_\_\_\_\_, have read and fully understand the information provided to me by Braeden Guter in his Professional Disclosure Statement.

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Client/Guardian Signature

Date

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Client/Guardian Signature

Date

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Counselor Signature

Date

**Intake Form**

**Personal Information**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Okay to leave a message? Y / N

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Okay to leave a message? Y / N

Email address: \_\_\_\_\_ Okay to leave a message? Y / N

Relationship Status (circle):

Single Dating Engaged Married Co-habiting Separated Divorced Widowed

Current Partner's Name: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Years Together (dating, married, etc): \_\_\_\_\_ Anniversary: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

How did you hear about us?

\_\_\_\_\_

**Personal Experience**

Where were you born? \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

Were there any unusual circumstances regarding your conception or birth?

\_\_\_\_\_

Were your parents married when you were born? Y / N

Are your parents currently married? Y / N

If your parents divorced, how old were you and why did it occur?

\_\_\_\_\_

What is/was your mother like? How did she treat you as a child?

\_\_\_\_\_

What is/was your father like? How did he treat you as a child?

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How did your parent(s) typically discipline you?

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What were your favorite things to do as a child?

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List your siblings, and their ages in chronological order (oldest to youngest):

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation (circle): Full Half Step

What was your birth order? 1 2 3 4 5 6 7 8 9 10

How many different places did you live before you finished high school? \_\_\_\_\_

Circle any of the following that describes your family and home atmosphere as a child:

Alcoholism	Democratic	Neglectful	Prejudice	Stable
Affectionate	Distant	No Fun	Rigid	Cold
Angry	Fighting	Overprotective	Sexual Abuse	Poverty
Close	Frightening	Physical Abuse	Mental Illness	Trusting
Competitive	Moving Excessively	Physical Illness	Supporting	Safe

Did anyone in your family die before you were 18? Y / N

Who: \_\_\_\_\_

How old were you? \_\_\_\_\_

Did anyone in your family attempt or commit suicide? Y / N

Who: \_\_\_\_\_

How old were you? \_\_\_\_\_

**Social Experience**

Explain and indicate how satisfied you are with your current social life:

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Describe your relationship with your best friend and how often you get together:

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When did you first begin dating? Were your early dating experiences positive?

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**Education and Employment Experience**

Highest Grade in school or degree(s) completed:

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Briefly explain the number of times, what grades, and the reason you had to change schools while growing up:

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Are you currently employed? Y / N      Position: \_\_\_\_\_

Time in current job: \_\_\_\_\_

**Spiritual Experience**

Please describe your family's spiritual or religious atmosphere while you were growing up:

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When did you develop your current beliefs?

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List a few words to describe your personal beliefs:

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Do your family and friends share your current beliefs?

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Any religious or spiritual problems that concern you?

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**Medical History**

When was your last physical examination? \_\_\_\_\_

Name of your physician? \_\_\_\_\_

List any injuries, accidents, or surgeries:

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List any head injuries, seizures, or loss of consciousness you have had:

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List any medications (prescription and non-prescription) that you are taking:

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Do you or your family members currently have or have ever had any of the following:

(check all that apply)

	<u>Self</u>	<u>Family</u>
Heart problems	_____	_____
Cancer	_____	_____
Nervous breakdown	_____	_____
Stroke	_____	_____
Chronic illness	_____	_____
Alcohol or drug use	_____	_____
Legal problems	_____	_____
Learning disability	_____	_____
Depression	_____	_____
Other _____	_____	_____

**Chemical/Substance History**

Does/did anyone in your family use alcohol or drugs (either prescription or street drugs) Y / N

What alcoholic beverages did/do you use? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

When did you have your last drink? \_\_\_\_\_

What street drugs did/do you use? \_\_\_\_\_

When did you last use? \_\_\_\_\_

Do you use nicotine? \_\_\_\_\_ How much daily? \_\_\_\_\_

Caffeine? \_\_\_\_\_ How much daily? \_\_\_\_\_

**Mental Health History**

Have you ever been in counseling or therapy before?

\_\_\_\_\_

In a few words describe your counseling experience:

\_\_\_\_\_

Have you ever been hospitalized for an emotional/mental health disturbance? Y / N Describe:

\_\_\_\_\_

\_\_\_\_\_

Have you ever tried to end your own life? Y / N If yes, please provide date(s):

\_\_\_\_\_

**Personality Information:**

As you see yourself, what kind of person are you? Describe yourself:

\_\_\_\_\_

\_\_\_\_\_

If I were to ask other people to describe you, what five words would come up most frequently?

\_\_\_\_\_

What are your greatest fears?

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Identify any irrational, negative, or 'horrible' thoughts that bother you:

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Identify any habits, practices, or behaviors that you would like to change:

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State in your own words what you would consider to be the nature of your main problem(s):

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Describe when and how your problem(s) began:

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What have you done about it?

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Please circle any of the following which concern you:

Anger	Depression	Fears	Shyness	Sexual Problems	Suicidal thought
Separation	Divorce	Finances	Friends	Self-control	Nervousness
Sleep	Work/school	Stress	Relaxation	Headaches	Tiredness
Memory	Ambition	Energy	Insomnia	Legal Matters	Making Decisions
Loneliness	Inferiority	Education	Career	Concentration	Relationships
Marriage	Health	Pornography	Nightmares	Children	Eating Problems
Dreams	Spirituality	Parenting	Gambling	Sexual Abuse	Physical abuse
Thoughts	Body image	Temper	Alcohol use	Spiritual abuse	Unhappiness

List three goals you have for self-improvement:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List three major strengths or abilities you have:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## “FIRST IMPRESSIONS”

It has been said that, “*a picture is worth a thousand words.*” Please draw and/or briefly describe what you hope to ultimately gain from your counseling experience at **A New Life Christian Counseling**. The purpose of this exercise is to gain a clearer understanding of your desires & goals, not assess your artistic abilities, so please be encouraged to express yourself regardless of your level of talent.

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**REDUCED FEE SCHEDULE**

ANLCC’s internship program is able to provide services affordably, according to the following policy:

- 1) Fees are based on a sliding scale, according to client’s household income. See chart below for the schedule of fees.
- 2) Fees are paid at the start of each session, unless client billing has been previously arranged.
- 3) Cash, credit/debit or checks (made payable to your counselor) are acceptable forms of payment.
- 4) Sessions are typically 50 minutes long, except initial “intake” sessions and some couples’ sessions, which are 75 minutes long and billed at 1.5 times the session amount.
- 5) A 24-hour notice must be given if you are not able to make your session. Otherwise, you will be charged for the complete session. Insurance cannot be billed for missed appointments.

Look over the Fee Schedule and circle the amount that corresponds to your household's monthly net (take home) income. Fees may be reviewed every 3 months, at your request only.

<b>Net Income per month</b>	<b>Session Fee</b>
<b>Below \$1700</b>	\$20
<b>1701- 2100</b>	\$24
<b>2101- 2500</b>	\$28
<b>2501- 2900</b>	\$32
<b>2901- 3300</b>	\$35
<b>3301- 3700</b>	\$38
<b>3701- 4100</b>	\$42
<b>4101- 4500</b>	\$45
<b>4501 &amp; Above</b>	\$50

Your hourly fee for counseling is \$\_\_\_\_\_ per session and you will be expected to pay this at the time of

each session. (Session Fee X 1.5 = \_\_\_\_\_, if applicable)

\_\_\_\_\_  
 Client

\_\_\_\_\_  
 Date

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Counselor \_\_\_\_\_

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Date \_\_\_\_\_



**Intern Counselor Competencies & Referral Notice**

I, \_\_\_\_\_ acknowledge that I have been informed that Braeden  
(Client Name)

Guter is masters level student intern counselor at A New Life Christian Counselors, under the supervision of Breanna Jeffries, LMHC (License # LH 60336941). As such, he has not yet completed all required coursework and training for degree completion yet has completed the minimum required coursework and practicum training to effectively assist many individuals and couples within the scope of education, training and experience at this point in his professional development.

While every effort will be made by Braeden Guter to provide competent, skilled and professional care each session, I understand that there still may be limitations to his ability to provide the level of mental health care/counseling support that may be needed to reach my treatment goals. I have also been informed that I can discuss the matter of my care related to this notice with either/both Braeden Guter or Breanna Jeffries without such discussion affecting the level of my current care with Braeden Guter. In such situations where I, Braeden Guter, or Breanna Jeffries may determine that additional or different mental health care/counseling support would be beneficial, I will be provided at least two qualified counselor referral options for services.

I hereby acknowledge having received a copy of this Intern Competencies and Referral Notice.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Intern Signature \_\_\_\_\_ Date \_\_\_\_\_



**Consent to receive Christian Counseling**

Your signature following the statements below constitutes your agreement and consent to receive Christian counseling from your counselor at A New Life Christian Counselors, and an acknowledgement that you have read and understood this agreement. This also means that you have discussed any questions regarding this contract with your counselor.

I request that as part of the professional services provided by Braeden Guter, that he make available to me ministry-oriented services. These include, but are not limited to, personal prayer, Scripture reading from the Bible, Christian books, other Christian resources and any Christian practices that could be meaningful to me or are requested by me. Braeden Guter is released to use Christian terms and language in counseling me, and to utilize Christian spiritual practices such as inner healing prayer and addressing issues concerning Spiritual distress.

**I/we, \_\_\_\_\_ have read, understood, and received a copy of this agreement.**

**Signature of Client: \_\_\_\_\_ Date \_\_\_\_\_**

**Signature of Counselor: \_\_\_\_\_ Date \_\_\_\_\_**