A New Life
Christian Counselors
A New Life Is Possible One Step at a Time
www.anlcc.com

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PROFESSIONAL DISCLOSURE STATEMENT FOR BREANNA JEFFRIES, LMHC

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: I believe there is tremendous potential for personal exploration and growth within each individual. My role as a counselor is to assist those individuals, couples, families, and groups that are motivated to change at least one aspect of their thoughts, feelings, or behaviors. As a licensed mental health counselor, it is my goal to use various approaches and techniques to best serve your needs. I believe that for progress to be made in therapy, you must find a sense of meaning and purpose for your life and find practical strategies and skills to help you through immediate life circumstances. In addition, for therapy to be beneficial, it is important for the client and counselor to agree upon and mutually commit to a general course of action, regardless of the particular approach or technique.

Therapy generally consists of three, possibly four, "phases." Phase one will primarily consist of listening to and understanding your 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 you. 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 you work through and overcome 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, or brief text/email with signed consent. 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 Association of Christian Counselors and 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 services received, desirous of a second opinion or referral, or if intending to discontinue appointments.

EDUCATION: My education includes a Master of Arts Degree in Counseling Psychology. Additionally, I hold a Bachelors of Arts Degree in Behavioral Science with a minor in Youth Ministry.

I am a Licensed Mental Health Counselor by Washington State Department of Health (#LH 60336941). I have received additional training in crisis counseling and suicide prevention, trauma, dissociation, Motivational Interviewing, Cognitive Behavioral Therapy, and Clinical Supervision, among others.

In accordance with Washington State Law, I participate in continuing education and training in order to further enhance the effectiveness of my counseling and facilitator skills, as well as comply with Washington Department of Health standards. As part of my personal and professional growth, as well as ongoing commitment to improvement and integrity, I maintain regular consultation with other professionals in the counseling field.

FEES: My fees for individual and couples therapy are $120 per session. Individual sessions are typically 50 minutes long, except the initial "intake" session, which can be 90 to 120 minutes long and would be billed at 1.5 to 2.0 times the session amount. Likewise, some couples and family sessions can last 90 to 120 minutes and are billed at the same rate as noted above. Rates and payment arrangements will be determined at the time of scheduling. At this time, I do have a limited amount of sliding scale slots available; please ask if you are in need of a reduced rate.

CANCELLATION POLICY: Clients are expected to contact the counselor at least 24 hours in advance to cancel or reschedule an appointment. Full fees will be charged for missed sessions that are not cancelled 24 hours in advance.

EMERGENCY SERVICES: If in need of emergency services, the client should call a crisis line in Clark County at 360.696.9560 or 1.800.626.8137, or call 911.

ACKNOWLEDGEMENT OF RECEIPT: I/We, _____, have read and fully understand the information provided to me by Breanna Jeffries, LMHC in this Professional Disclosure Statement.

_____ _____
Client/Guardian Signature Date

_____ _____
Client/Guardian Signature Date

_____ _____
Breanna Jeffries, LMHC Date

INTAKE FORM

Today's Date: _____/_____/_____

Personal Information

Name:			Age:	DOB: / /
(Circle All that Apply): Single Dating Married Separated Divorced			Cell Phone #: ( ) -	
Address:			Home Phone #: ( ) -	
City:	State:	Zip:	Work Phone #: ( ) -	
# of Children:	Their Ages:		Email:	
Current Partner's Name (If Applicable):			Their Phone #: ( ) -	
Nearest Relative Living Separately:			Their Phone #: ( ) -	

Education / Employment Information

Last grade completed in school:	Are you employed now? _____Yes _____No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

Spiritual History

List a Few Words to Describe Your Personal Faith:
List Those Who Support You Most Spiritually:

General Information

How did you hear about us?
Briefly describe problems you want help with:
How much have you worked during the past two years? Part Time Full Time Other:
Describe your education (# of years of school, special training, etc.):

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.):

Please list/describe any previous counseling experience(s):

Did anyone in your family die before you were 18 years old? Yes No Who?

How old were you? _____ Other family deaths?

When were you last examined by a physician?

Present physician's name:

Phone number:

List any medications you are now taking (prescription and nonprescription):

List any major health problems for which you have received treatment:

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

	SELF	FAMILY
HEART PROBLEMS	_____	_____
CANCER	_____	_____
NERVOUS BREAKDOWN	_____	_____
STROKE	_____	_____
CHRONIC ILLNESS	_____	_____
ALCOHOL OR DRUG ABUSE	_____	_____
LEGAL PROBLEMS	_____	_____
LEARNING DISABILITY	_____	_____
DEPRESSION	_____	_____
OTHER _____	_____	_____

List everyone currently living in your residence, including family and other:

NAME	AGE	RELATIONSHIP

NAME	AGE	RELATIONSHIP

	YES	NO	DON'T REMEMBER
Have you been abused or assaulted?			
Did you witness abuse between your parents?			
Did you witness abuse between parent and child?			
Briefly describe your childhood:			

Please circle any of the following which concern you:

NERVOUSNESS	DEPRESSION	FEARS	SHYNESS
SEXUAL PROBLEMS	SUICIDAL THOUGHT	SEPARATION	DIVORCE
FINANCES	ANGER	SELF-CONTROL	FRIENDS
SLEEP PROBLEMS	STRESS	WORK/SCHOOL	RELAXATION
HEADACHES	TIREDNESS	LEGAL MATTERS	MEMORY
AMBITION	ENERGY	INSOMNIA	MAKING DECISIONS
LONELINESS	INFERIORITY FEELINGS	CONCENTRATION	EDUCATION
CAREER CHOICES	MARRIAGE/RELATIONSHIPS	HEALTH PROBLEMS	TEMPER
NIGHTMARES	CHILDREN	EATING PROBLEMS	UNHAPPINESS
SEXUAL ABUSE	PHYSICAL ABUSE	BOWEL TROUBLES	BEING A PARENT
MY THOUGHTS	STOMACH PROBLEMS	GAMBLING	BINGE EATING
EATING TOO LITTLE	TOO HEAVY OR THIN	SPIRITUALITY	UNFORGIVENESS

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	**Yes, I Used**	**If yes, age at first use**	**When using, frequency of use (daily, weekly, etc.)**	**How long since last used?**
Tobacco					
Alcohol					

Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Meth/Amphetamine/Speed					
Hallucinogens (LSD, Mushrooms, etc.)					
Coffee					
Other					

Please circle any of the following strengths you have:

CONFIDENT HARD WORKER ORGANIZED GRACIOUS SYMPATHETIC DEPENDABLE
SENSITIVE LOGICAL LOYAL GOOD LISTENER DECISIVE
UNDERSTANDING RESPONSIBLE PATIENT SENSE OF HUMOR
OTHER

Please add any additional information which you feel may be helpful to me:

A New Life
Christian Counselors

Email/Text Messaging Consent Form

If you would like to communicate with me via email and/or text messaging, please read this important information.

This fact sheet and consent form will inform you of the risks in communicating via email and/or/ text messaging. Be advised: I will not discuss information related to counseling via email or text messaging. Information not related to discussions in the counseling room between client and counselor, such as the desire to cancel or schedule an appointment will be answered within 24 hours of the receipt of the email/text message, provided this consent form has been signed by the client.

IN AN EMERGENCY PLEASE CALL 911

Email and/or text communications are two-way communications. However, responses and replies to email and/or text messages sent to or received by either you or me may be hours or days apart. This means that there could be a delay in receiving a response; therefore, if you have an urgent or emergency situation, ***DO NOT*** *contact me via email or text.* ***CALL 911.***

BE AWARE OF WHAT YOU COMMUNICATE

Although all information email and/or/texted to me will be kept confidential, email and/or text messages on your phone have inherent privacy risks – especially when your cell phone and/or computer is provided through your employer, family member, or when access to your messages are not password protected.

I understand and agree to the following:

- I certify that the email address and/or cell phone number provided on this request is accurate, and that I accept full responsibility for messages sent to and from this email address and/or cell number.
- I have read and understood the important information provided above.
- I agree to hold Breanna Jeffries, LMHC harmless from any and all claims and liabilities arising from or related to this request to communicate via email and/or text messages.

_____	_____	_____
Printed name of Client	Email address	Cell phone number

_____	_____
Signature of Client	Date

_____	_____
Breanna Jeffries, LMHC	Date

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Consent to Receive Christian Counseling

Your signature following the statements below constitutes your agreement and consent to receive Christian counseling from your counselor, Breanna Jeffries 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. You are under no obligation to sign this consent form. If you do wish for spiritual conversations to be a part of your counseling process, please continue reading, and sign below.

I request as part of the professional services provided by Breanna Jeffries, that she makes 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. The above named counselor 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.

_____ _____
Client/Guardian Signature Date

_____ _____
Client/Guardian Signature Date

_____ _____
Breanna Jeffries, LMHC Date