A New Life
Christian Counseling

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

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PROFESSIONAL DISCLOSURE STATEMENT FOR ESTHER PFEIFFER, LMHCA

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 and couples that are motivated to change at least one aspect of their thoughts, feelings, or behaviors. As a Licensed Mental Health Counselor Associate, it is my endeavor to utilize various approaches and techniques in order to best serve the needs of the client. I believe that in order for progress to be made in therapy, one must find a sense of meaning and purpose for their lives, as well as find practical strategies and skills for working 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 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 an approved form of communication via technology (i.e. email, phone, etc.). 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. In the event that the counselor and client unintentionally meet in a setting outside of the office setting (i.e. grocery store, church, etc.), it is understood that the counselor will not initiate contact, nor disclose the nature of their relationship to the client should the client choose to introduce them socially.

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 services received, desirous of a second opinion or referral, or if intending to discontinue appointments.

EDUCATION: I heave earned a Masters of Arts degree in Counseling from Multnomah University, as well as a Bachelor of Science degree in Social and Behavioral Studies from George Fox University.

I have taken additional coursework in a variety of specializations, including adolescents, premarital counseling, couples counseling, grief and loss, and emotional intelligence.

I am a Licensed Mental Health Counselor Associate with the Washington State Department of Health (MC60606878). In accordance with Washington State Law, I am under the ongoing clinical supervision of Brad Peterson, LMHC, who can be reached at 360-980-7906. 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 the state departments' 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: Individual sessions are typically 50-minutes unless prearranged otherwise. Couple, family, and individual intake sessions are typically 75-minutes unless prearranged otherwise. The fee for a 50-minute individual session is $90 and a 75-minute couple, family, or individual intake session is $135. Fees are due at time of service, and are payable via cash, personal check, or debit or credit card. Specific financial arrangements, including discounted rates due to low-income or financial difficulty, are discussed and established during the initial intake session.

Esther Pfeiffer, LMHCA does not bill insurance companies for counseling services provided. However, you may request during your initial intake session that an invoice be provided to you at the end of each month containing information which can be used to request reimbursement from your insurance provider. If you are planning on submitting insurance claims to your provider, it is first recommended that you call your provider and confirm coverage. Additionally, your signature below indicates that you understand that your claim with your insurance provider may be rejected at their discretion based on your coverage, as well as their policies, and that payment to Esther Pfeiffer for services are final even in the event of denied claims.

CANCELLATION POLICY: Clients are expected to contact the counselor at least 24 hours in advance to cancel or reschedule an appointment. Full fees are charged for missed sessions or sessions cancelled or rescheduled with less than a 24 hour notice.

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 Esther Pfeiffer, LMHCA in her Professional Disclosure Statement.

_____ _____
Client/Guardian Signature Date

_____ _____
Client/Guardian Signature Date

_____ _____
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 Cohabitating 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? _____

How did your parent(s) typically discipline you? _____

What were your favorite things to do as a child? _____

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: _____

_____

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

_____

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

_____

Education and Employment Experience

Highest Grade in school or degree(s) completed: _____

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

_____

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: _____

_____

When did you develop your current beliefs? _____

List a few words to describe your personal beliefs: _____

_____

Do your family and friends share your current beliefs? _____

Any religious or spiritual problems that concern you? _____

_____

Medical History

When was your last physical examination? _____ Name of your physician? _____

List any injuries, accidents, or surgeries: _____

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

_____

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

_____

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

	Self	Family
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 even 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?

_____ _____ _____ _____ _____

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

_____

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

_____

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

_____

Describe when and how your problem(s) began: _____

_____

What have you done about it? _____

List three goals you have for self-improvement:

1. _____
2. _____
3. _____

List three major strengths or abilities you have:

1. _____
2. _____
3. _____

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	Stress	Work/school	Relaxation	Headaches	Tiredness
Memory	Ambition	Energy	Insomnia	Legal Matters	Making decisions
Loneliness	Inferiority	Education	Career	Concentration	Marriage
Relationships	Health	Temper	Nightmares	Children	Eating problems
Unhappiness	Spirituality	Parenting	Gambling	Sexual abuse	Physical abuse
Thoughts	Body image	Pornography	Alcohol use	Spiritual abuse	Dreams

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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 ANLCC. 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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FEE SCHEDULE

Esther Pfeiffer, LMHCA provides services affordably, according to the following policy:

1) Fees for a 50-minute session is $90 and a 75-minute couple or individual intake session is $135. A discounted rate may be discussed, and agreed upon as notated and documented on this form.

2) Fees are paid at the end 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.

(Please discuss with your counselor if there is a need for a reduced session fee due to low income or financial difficulty before completing the information below.)

Your hourly fee for counseling is $_____ per 50-minute session and you will be expected to pay this at the time of each session. (Session Fee X 1.5 = _____, if applicable)

_____ _____
Client Date

_____ _____
Counselor 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 at A New Life Christian Counseling (ANLCC), 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 _____ that they 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. 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.

Signature of Client: _____ Dated _____, 20___

Signature of Counselor : _____ Dated _____, 20___