



**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.

**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 have 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. The fee for a 50-minute individual session is \$100. 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 Cohabiting 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

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 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?

\_\_\_\_\_

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) Fee for a 50-minute session is \$100. 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 50 minutes long.
- 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. Rare exceptions may be made for unforeseen or unavoidable circumstances. Your counselor reserves the right to make the final decision.

(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 service.

\_\_\_\_\_  
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\_\_\_\_