



**A New Life**  
Christian Counseling

*A New Life Is Possible One Step at a Time*  
[www.anlcc.com](http://www.anlcc.com)

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### **Professional Disclosure Statement for Jeremiah Peck, 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 that there is a tremendous opportunity and potential for physical, emotional, spiritual, and relational healing and growth that can be achieved through counseling. My role as a counselor is to come alongside and assist individuals, couples, families, and groups as they journey towards growth and healing. I do not operate with an agenda when we meet, rather, I listen for what is important to you and the reasons for you coming seeking counseling and we move towards your goals together"

#### **Clinical Relationship:**

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 office sessions, phone sessions, or video sessions as arranged. 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, 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.

#### **Nature of Counseling:**

Counseling is understood to be a choice made by the client, among available options. Options can include, support groups, self-help resources, other modes of treatment, or medical treatment. If counseling 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 longer 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, Training, and Licensure:**

"I have earned a Masters of Arts degree in Counseling from Multnomah University, as well as a Bachelor of Science degree in Bible and Theology with a minor in Psychology, also from Multnomah University. I am currently working towards earning a PhD in Counselor Education and Supervision in my work of teaching and supervising developing counselors.

I have taken elective courses in approaches and interventions in a variety of specializations, including sexual addiction treatment, premarital counseling, couples counseling, suicide prevention, crisis counseling, grief and loss, trauma and attachment, pastoral counseling, and advanced diagnosis.

I am a Licensed Mental Health Counselor with the Washington State Department of Health (LH60967738). 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 pastoral and counseling fields."

**Sessions and 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 \$120, and a 75-minute couple, family, or individual intake session is \$180. Fees are due at time of service, and are payable via cash, personal check, or debit or credit card. Specific financial arrangements, due to low-income or financial difficulty, are discussed and established during the initial session.

Jeremiah Peck, LMHC is an out-of-network provider, and 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. A questionnaire with important questions to ask can be provided to you at your request. 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 Jeremiah Peck 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. In the event of a cancelled appointment with less than a 24 hour notice, or a missed appointment with no notification, the client will be billed according to the following schedule either by automatic charges to the credit or debit card on file, or by mailed invoice.

- Missed appointments with no notification of cancellation or rescheduling -- \$50.00
- Cancelled or rescheduled appointments with less than a 24 hour notice -- \$25.00
- Cancelled or rescheduled appointments with more than a 24 hour notice -- no charge

**Use of technology for communication:**

It is understood that the use of technology for communication (email, text messaging, etc.) is limited to matters related to scheduling, cancelling, or rescheduling appointments, and for privacy, content related to treatment will not be discussed via these platforms.

**Administrative staff:**

The administrative staff of Jeremiah Peck (DBA: Eleos Christian Counseling) are involved in scheduling, administration, and billing. As such the administrative staff will have access to a client's personal information, limited to the scope reasonable to perform these activities. They are also held to the same legal and ethical standards of confidentiality, and do not have direct access to clinical notes.

**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 Jeremiah Peck, LMHCA in his Professional Disclosure Statement, agree to the terms and conditions outlined above, and give my informed consent to receive counseling services.

\_\_\_\_\_  
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

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: \_\_\_\_\_

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## "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**

Jeremiah Peck, LMHC provides services, according to the following policy:

- 1) Fees for counseling services are charged according to the following schedule:
  - a. 50-minute individual session -- \$120
  - b. 75-minute couple, family, or individual intake session -- \$180.
  
- 2) Specific financial arrangements, due to low-income or financial difficulty, are discussed and established during the initial session.
  
- 3) Fees are paid at the end of each session, unless client billing has been previously arranged.
  
- 4) Cash, checks (made payable to your counselor), and debit and credit cards are accepted for payment.
  
- 5) Sessions are typically 50 minutes long, except initial "intake" sessions and couples sessions, which are 75 minutes long and billed at 1.5 times the session amount.
  
- 6) A 24-hour notice must be given if you are not able to make your session. Otherwise, you will be charged according to the following schedule:
  - a. Missed appointments with no notification of cancellation or rescheduling -- \$50.00
  - b. Cancelled or rescheduled appointments with less than a 24 hour notice -- \$25.00
  - c. Cancelled or rescheduled appointments with more than a 24 hour notice - no charge
  
- 7) Fees for additional services outside the scope of standard treatment include:
  - a. Client request for a document to be produced and submitted to their place of employment, academic institution, place of residence, or other party for any purpose with information pertaining to diagnosis or treatment -- \$50.00 per document, per occurrence.
  - b. Time related to court appearances, subpoenas, depositions, testimonies, or other document production related to legal activities or travel thereto, as well as time by phone, in-person, or otherwise, pertaining to the discussion of information related to treatment at the request of the client to any third-party, is billed at \$120 per hour, prorated to the nearest 15 minutes, plus any applicable mileage, postage, or fees incurred by the counselor

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 (75-minute session) = \$\_\_\_\_\_, if applicable)

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor

\_\_\_\_\_  
Date