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## **PROFESSIONAL DISCLOSURE STATEMENT FOR KIMBERLY CRUM**

Welcome! Before we start counseling it is both my desire and requirement of State law to provide you with the following written disclosure statement. This information regarding the counseling relationship has been provided for your protection and assistance in making an informed choice about treatment. It provides information regarding my approach to counseling, education, training and credential, your rights as a client, and my fees.

### Credentials and Approach to Counseling

Kimberly Crum is a counseling student intern in the M.A. Counseling program at Western Seminary, Portland, Oregon, degree anticipated April, 2018. She obtained a B.A. in Human Development from Warner Pacific College. Coursework completed includes training in ethical practice, cultural diversity, human development, helping relationships, suicide prevention, pathology diagnosis, neuropsychology, and biblical literature. Licensed Counselors are required to participate in 40 hours of continuing education every two years. As a counseling student intern in a program approved by the Oregon Board of Licensed Professional Counselors and Therapists, she will abide by its Code of Ethics as set forth in OAR chapter 833, division 100; the laws of the State of Oregon; and the American Counseling Association Code of Ethics.

Kimberly has experience in working with low-income families as a family advocate and has a heart for those in need. She has worked to help families find community resources to assist in the specific needs for their families and she looks forward to assisting them in mental health areas as well. Her approach to therapy incorporates a Christian worldview with cognitive behavior methods (helping one identify thoughts and behaviors and moving toward positive change) as well as attachment therapy (looking at past attachments in relationships and how they affect current situations). She views counseling as a collaborative effort in helping clients to recognize strengths, identify needs, understand conflicts, discover new options, set personal development goals, and make informed choices.

When a client talks about personal information and the counselor responds with respect and authenticity, sessions may seem emotionally intimate. To maintain a safe and beneficial environment, the counseling relationship will remain on a professional level, and limited to sessions in the office or over the phone, focusing on client concerns. For the benefit of the client, the client and counselor will not engage in physical contact, socialize, give gifts to each other, nor establish any relationship other than the professional counseling relationship. Cultural sensitivity may require some minor modification.

### Confidentiality & Client Rights

Everything said in counseling, and even the fact that you are in counseling, is confidential and will not be disclosed except when, based upon information gained from the client or a third party, the counselor is required or permitted by the HIPAA Privacy Standard or Oregon and Washington state law. As a client of a counseling intern practicing within the guidelines of the Oregon Board of Licensed Professional Counselors and Therapists, you have the following rights:

1. To expect that a counseling intern has met the minimal qualifications of training and experience required by state law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:

- a) Reporting suspected child abuse;
  - b) Reporting imminent danger to client or others;
  - c) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
  - d) Providing information concerning licensee case consultation or supervision; and
  - e) Defending claims brought by client against the intern or licensee;
7. To be free from being the object of discrimination on the basis of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Information may also be disclosed if a client signs a written authorization. Electronic transmission and caller identification--by phone, cell phone, email, FAX, or internet, increases risk for breach of confidentiality.

In keeping with generally accepted standards of practice, periodic supervision and consultation is made regarding the management of cases with other health professionals, who are bound by the rules of confidentiality as stated herein. Kimberly is supervised by Breanna Jeffries, LMHC. Breanna may be contacted directly at 360-980-7906. As a graduate counseling student, I am periodically required to present clinical samples of my work to faculty and peers in class. Efforts will be made to protect client identity.

#### Video Taping

For the purpose of supervisory review, I may request that a session be recorded. An additional disclosure statement will be provided at the time of taping, should it arise. If this is something that you are unwilling to consent to, or otherwise feel uncomfortable with, please let me know during the intake process.

Initial here: \_\_\_\_\_ accept upon request \_\_\_\_\_ deny any taping

#### Fees

My fees for individual therapy are based upon a sliding scale for the amount of time spent or reserved, at the rate of \$10 to \$40 per session. Sessions are typically 50 minutes long and clients are encouraged to be here on time to allow for the full session. Rates and payment arrangements will be determined at the time of scheduling.

#### 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.

#### Voluntary Participation

Counseling involves personal exploration and potential life change that, whether positive or negative, may alter significant relationships and how a client views him or herself. Change can often create temporary distress. Participation in counseling is understood to be an informed choice made by the client. Since many factors influence the counseling process, specific outcomes cannot be guaranteed and clients may, or may not, maximally benefit.

Some clients need only a few sessions to achieve their goals, while others may require sessions over several months or years of counseling. The client may choose not to seek treatment at this time. Options include other therapists, books, support groups, self-help resources, medical treatment, pharmacological therapy, and other modes of treatment. A client has the right to terminate counseling at any time, however, it is understood that terminating prematurely may result in the return or worsening of symptoms.

Communication between client and counselor is considered to be part of the clinical record, which is accessible to the client upon written request to view or to obtain copies. Records are maintained for a period of seven years from date of termination. Records of minor clients will be retained for a period of seven years after their 18<sup>th</sup> birthday or seven years from the date of termination, whichever is the later. \_

#### Emergency Services

If in need of emergency services, the client should call a crisis line at (800) 273-TALK, (800) SUICIDE, (360)696-9560, (503)988-4888, or 911.

ACKNOWLEDGMENT

I/We have received a copy of the *Notice of Privacy Practices*, and this disclosure statement about the counselor. I/ We have read the information, were given the opportunity to ask questions, and understand the contents.

As a contingency of my/our counseling, I/we \_\_\_\_\_ agree to pay the counseling fee as follows:

- (1) at the start of each session;
- (2) the fee of \$\_\_\_\_\_ for each counseling session of 50 minutes;
- (3) the fee can be periodically adjusted or may be discounted based upon demonstrated need;
- (4) the full session fee charged if the client fails to cancel a minimum of 24 hours prior to any scheduled appointment;
- (5) a prorated hourly fee charged for phone calls made by the counselor at my/our request; and
- (6) all financial obligations, regardless of insurance coverage or reimbursement. I understand there are no additional hospital or room fees.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Client/Guardian Signature

**Personal Information**  
(use back if needed for more room)

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

Sexual Orientation: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

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

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

Names and Ages: \_\_\_\_\_

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

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

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? If so, who?

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Any religious or spiritual problems that concern you? If so, what?

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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)

	<b>Self</b>	<b>Family</b>
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? If so, describe your experience in a few words:

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

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         | Energy      | Insomnia     | Legal Matters | Making Decisions | Ambition         |
| Loneliness     | Inferiority | Education    | Career        | Concentration    | Marriage         |
| Relationships  | Health      | Temper       | Nightmares    | Children         | Eating problems  |
| Thoughts       | Body Image  | Pornography  | Alcohol use   | Spiritual abuse  | Dreams           |
| Physical abuse | Unhappiness | Spirituality | Parenting     | Gambling         | Sexual abuse     |

Please note anything else that you might want us to know:

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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 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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**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.

Net Income per month	Session Fee
<b>Below \$1700</b>	\$10
<b>1701- 2100</b>	\$14
<b>2101- 2500</b>	\$18
<b>2501- 2900</b>	\$22
<b>2901- 3300</b>	\$25
<b>3301- 3700</b>	\$28
<b>3701- 4100</b>	\$32
<b>4101- 4500</b>	\$35
<b>4501 &amp; Above</b>	\$40

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

\_\_\_\_\_

Counselor

\_\_\_\_\_

Date

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**Intern Counselor Competencies & Referral Notice**

I, \_\_\_\_\_ acknowledge that I have been informed that Kimberly Crum  
(Client Name)  
is a master's level student intern counselor at A New Life Christian Counseling, under the supervision of Breanna Jeffries, LMHC (License # LH60336941). As such, she 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 her professional development.

While every effort will be made by Kimberly Crum to provide competent, skilled and professional care each session, I understand that there still may be limitations to her 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 Kimberly Crum or Breanna Jeffries without such discussion affecting the level of my current care with Kimberly Crum. In such situations where I, Kimberly Crum, 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 \_\_\_\_\_

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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 Kimberly Crum that ministry oriented services be made available to me. These include, but are not limited to, personal prayer, Scripture reading and/or quotations/references from the Bible, Christian books, other Christian resources and any Christian practices that could be meaningful to me or are requested by me. Kimberly Crum 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 release above named counselor to use Christian terms and language in counseling. I/We received a copy of this agreement.

Client Signature: \_\_\_\_\_ Dated \_\_\_\_\_, 20\_\_\_\_

Intern Signature: \_\_\_\_\_ Dated \_\_\_\_\_, 20\_\_\_\_