

**PROFESSIONAL DISCLOSURE STATEMENT FOR LAURI BORGMEYER, 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: Each person has the potential to explore, grow, and live an abundant life. My role as a counselor is to partner with individuals to help them explore their past, thought patterns, feelings, choices, and behaviors in order to promote growth and achieve positive change. As a licensed professional counselor, 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 the phone. 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 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 Masters of Arts in Counseling from Western Seminary. My Bachelors of Science was attained at Warner Pacific College.

I am a licensed counselor with the Washington State Department of Health (#LH 5630), as well as an Approved Supervisor for licensees with the Washington Department of Health.

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 the state's department standards. As part of my personal and professional growth, as well as ongoing commitment to improvement and integrity, I maintain weekly consultation with other professionals in the counseling field.

FEES: My fee for individual therapy is \$120.00 per session. Sessions are typically 50 minutes long, except for initial "intake" sessions, which are 90 to 120 minutes long and billed at 1.5 to 2.0 times the session amount. 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.

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 Lauri Borgmeyer, MA, LMHC in her Professional Disclosure Statement.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Lauri Borgmeyer, LMHC

\_\_\_\_\_  
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           |



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.

---

---

---

---

---



Crossroads Community Church  
7708 NE 78th St  
Vancouver, WA 98662  
Phone: (360) 975-7172  
Email: lauriborgmeyer@gmail.com

**Client Fee Agreement**

I am able to provide services according to the following policy

- 1) Sessions fees are \$120 per 50 minute session, unless another amount has been established between client and counselor
- 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 Lauri Borgmeyer, LMHC) are acceptable forms of payment.
- 4) For clients wishing to bill insurance, full fees for sessions are collected at the time of session. Lauri Borgmeyer will not submit invoices or bill insurances. However, clients can submit paid invoices to their insurance for reimbursement if desired.
- 5) Sessions are typically 50 minutes long, except initial "intake" sessions, which are 90-120 minutes long and billed at 1.5-2.0 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 for the complete session. Insurance cannot be billed for missed appointments.

Your hourly fee for counseling is \$\_\_\_\_\_ per 50 minute session and you will be expected to pay this at the time of each session.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor

\_\_\_\_\_  
Date





Crossroads Community Church  
7708 NE 78th St  
Vancouver, WA 98662  
Phone: (360) 975-7172  
Email: lauriborgmeyer@gmail.com

**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 Counselors (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 Lauri Borgmeyer, LMHC, that they make available to me ministry oriented services. 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. 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\_\_\_\_



Crossroads Community Church  
7708 NE 78th St  
Vancouver, WA 98662  
Phone: (360) 975-7172  
Email: lauriborgmeyer@gmail.com

**Email/Text Messaging Consent Form**

If you wish to communicate 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 Lauri Borgmeyer, 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

\_\_\_\_\_  
Lauri Borgmeyer, LMHC

\_\_\_\_\_  
Date