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 Michael Fernandez, LMHCA

Approach to Counseling:
I employ a holistic, client centered approach to counseling. Beginning with a strong foundation in neuroscience, I learn from each individual client how best to navigate our therapeutic relationship. I lean on empathy and humor to metaphorically walk with you as we discover your inherent strengths and areas of growth. Once your therapeutic goal is clear to both of us, we'll pick from a toolbox of approaches ranging from cognitive behavioral, to narrative, to mindfulness-based techniques. It's important to note that the growth in therapy comes from the unique therapeutic relationship and your own strength, not a counseling trick that only I hold the secret to.

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 sessions as arranged. 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. Personal gifts which are not for the benefit of you, the client, will not be exchanged. If our work involves meetings where more than one individual is present (i.e. couples or family work), and there is a dissolution of that unit (i.e. divorce), I may discontinue our meetings and refer to another professional. While working as a couple or family, I am not able to keep secrets, as it is often not advantageous or beneficial to the health of the unit.

I practice under the code of ethics of the American Counseling Association and 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; ACA; AACC, etc.);
- To be free from being the object of discrimination on the a protected status 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:
My Bachelor's degree is in Bible and Theology from Multnomah University in 2012. I then earned a Master of Arts in Counseling from Multnomah, graduating during COVID in 2020. I currently hold a license in the state of Washington as a Mental Health Counselor Associate. I also hold a certification as a facilitator of the Prepare/Enrich couples counseling program. I work under the supervision of Brad Peterson, LPC, LMHC.

Sessions and Fees:
Individual sessions are typically 50-minutes unless prearranged otherwise. 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.

Michael Fernandez, LMHCA is an out-of-network provider, and does not bill insurance companies for counseling services provided. 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 recommended that you call your provider and confirm coverage. Your signature below indicates that you understand that payment to Michael Fernandez for services is final regardless of the determination of your insurance provider.

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.

Telehealth:
If distance (telehealth) counseling (video, phone) services are requested, the following guidelines are applied:

- Client(s) engage in telehealth utilizing equipment and a connection that is secure and reliable for uninterrupted sessions.
- Client(s) are on time, personally prepared, and in an environment which is private and conducive to counseling (your counselor may ask you to show the space around you to ensure privacy and security.
- Client(s) are required to have access to headphones which will enable discussion of health and safety while ensuring privacy.
- In the event our telehealth session or connection is interrupted, the counselor will attempt to reestablish a connection at least twice and for at least ten minutes if sufficient session time is available. Sessions interrupted due to client's device, connection, or environment are billed in full. Further, in the event that the counselor has reasonable concern for your safety, or if connection is lost or interrupted and the counselor has reasonable concern for your safety, the counselor may at their discretion contact your emergency contact or emergency services.

Administrative staff:
The administrative staff of 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, _____ and _____, have read and fully understand the information provided to me by Michael Fernandez, 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 _____

Intake Form
(please fill out one copy per individual)

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

Michael Fernandez, LMHCA provides services, according to the following policies:

1) Fees for counseling services are charged on a sliding scale from $50-$100

REDUCED FEE SCHEDULE

In cases of client reported financial hardship, Michael Fernandez provides discounted counseling services according to the following sliding scale on a limited basis.

Gross Income per month	Session Fee
Below $1500	$50
$1501 - $2000	$55
$2001 - $2500	$60
$2501 - $3000	$65
$3001 - $3500	$70
$3501 - $4000	$75
$4001 - $4500	$80
$4501 - $5000	$90
$5001 and above	$100

To qualify for the Reduced Fee Schedule, you must show proof of gross annual income for all immediate family members living in your household. Gross income is all income from all sources before taxes. Applicants should provide a copy of any of the accepted income verification materials listed below.

Acceptable Income Verification:

- - Recent Federal Tax Return
- - IRS Form W-2 or 1099
- - Two (2) Current Pay Stubs

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)

2) Fees are paid at the end of each session unless client billing has been previously arranged.

3) Cash, checks (made payable to Eleos Christian Counseling), and debit and credit cards are accepted for payment.

4) 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

5) Fees for additional services outside the scope of standard treatment include:

d. 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.

e. 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

_____ _____

Client Name Printed Date

_____ _____

Client Signature Date