A New Life
Christian Counselors

Shasta Hickman
Fieldstone Park
11105 NE 14th Street, Suite 103
Vancouver, WA 98684
Phone: 971-303-9868
Email: shickman.ANLCC@gmail.com

PROFESSIONAL DISCLOSURE STATEMENT & PRACTICE POLICIES FOR SHASTA HICKMAN

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.

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, couples, families, and groups 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 goal to use various approaches and techniques to best serve your needs. I believe that for progress to be made in therapy, you must find a sense of meaning and purpose for your life and find practical strategies and skills to help you 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 approach or technique.

WHAT TO EXPECT FROM COUNSELING: Therapy generally consists of three, possibly four, "phases." Phase one will primarily consist of listening to and understanding your 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 you. 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 you work through and overcome 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, or brief text/email with signed consent. 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.

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 methods 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.

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, 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;
  - Defending claims brought by client against therapist;
  - Client has signed a release of information authorizing said disclosure.

EDUCATION/TRAINING/CREDENTIALING: My education includes a Master of Arts Degree in Counseling Psychology conferred through Concordia University Irvine. Additionally, I hold a Bachelor of Science Degree in Psychology: Pre-Counseling.

I am licensed by Washington State Department of Health as a Licensed Mental Health Counselor Associate (#LH MC60943341). I have received additional training in Emotion Focused Therapy, trauma, crisis counseling, suicide prevention, cultural diversity, human development, diagnosis, neuropsychology, addiction counseling, intimacy, sexuality, and gender, Motivational Interviewing, Cognitive Behavioral Therapy, and ethical practice, among others.

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 Washington Department of Health 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.

I practice under the code of ethics established by the American Counseling Association and the American Association of Christian Counselors.

FEES: My fees for individual and couple's therapy are $100 per session. Sessions are typically 50 minutes long, though the initial "intake" session may be 60 to 90 minutes and would be billed at 1.0 to 1.5 times the session amount. Likewise, some couples and family sessions can last 90 to 120 minutes and would be billed at the same rate stated above. We would discuss the need for sessions longer than the 50 minute hour, if needed. Rates and payment arrangements will be determined at the time of scheduling. I have a limited amount of lower cost client openings available; please inquire about current availability if you are in need of a reduced rate.

CANCELLATION POLICY: Clients are expected to contact the counselor at least 24 hours in advance to cancel or reschedule an appointment. Full fees will be charged for missed sessions that are not cancelled 24 hours in advance.

EMERGENCY SERVICES: If in need of emergent services, the client should call the mental health 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 Shasta Hickman, LMHCA in this Professional Disclosure Statement & Practice Policies.

______________________________		______________________________	
Client/Guardian Signature	Date	Client/Guardian Signature	Date

____

Shasta Hickman, LMHCA　　　Date

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A New Life Is Possible One Step at a Time
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Shasta Hickman's 2020 REDUCED FEE SCHEDULE

I am 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.
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
Below $1700	$65
1701- 2100	$75
2101- 2500	$80
2501- 2900	$85
2901- 3300	$90
3301- 3700	$95
3701 and Over	$100

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

____ _____________________
Shasta Hickman, LMHCA Date

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Distance Counseling Consent Form

1. I understand that my counselor and I wish to engage in distance counseling, either by phone, or online by video conferencing technology.

2. My counselor explained to me how video and/or phone sessions will not be the same as a direct client visit due to the fact that I will not be in the same room as my counselor.

3. I understand that distance counseling has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my counselor or I can discontinue distance counseling if it is felt that the phone or videoconferencing connections are not adequate for the situation.

5. I understand and agree that in order to gain the most value from the distance counseling experience, it is important to maintain the most professional and clinically-beneficial environment as possible. This includes (but is not limited to) ensuring that both client and counselor take every reasonable measure to limit distractions, both audible and visual, during sessions. This includes limiting the potential for background noise(s); other people, pets, etc. interrupting sessions, as well as for video conferencing—making sure lighting & background are adequate to clearly show face and shoulders on the screen.

6. I have had a direct conversation with my counselor during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that I have read or had this form read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of the procedure(s); and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

______________________________ ______________

Signature of Client Date

______________________________ ______________

Shasta Hickman, LMHCA Date

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Distance Counseling Emergency Protocol
(to be filled out by client receiving Distance Counseling services)

Client Name: ______________________________ DOB: _________ Phone: __________________

List all locations (City & State) in which you will/could use for your distance counseling sessions:

Personal emergency contact:

Name	Relationship	Phone

I, _____________________________ understand and agree that the counselor may contact local emergency services and/or the above referenced personal emergency contacts in the event that the counselor has reasonable concern for my safety, including circumstances where I am suddenly disconnected from communications in such a way that the counselor has reasonable concern for our safety. Depending on the nature of the counselor's concern, up to two attempts to re-establish contact or connection may take place prior to utilizing this emergency protocol.

____ ________________
Signature of Client Date

____ ________________
Shasta Hickman, LMHCA 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, Shasta Hickman 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. You are under no obligation to sign this consent form. If you do wish for spiritual conversations to be a part of your counseling process, please continue reading, and sign below.

I request as part of the professional services provided by Shasta Hickman, that she makes 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.

____________________________________ ____________

Client/Guardian Signature Date

____________________________________ ____________

Client/Guardian Signature Date

____________________________________ ____________

Shasta Hickman, LMHCA Date

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Email/Text Messaging Consent Form

If you would like to communicate with me 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 Shasta Hickman, LMHCA 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

______________________ ______________________

Shasta Hickman, LMHCA | Date

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Intake Form

Personal Information

Today's Date:___________

Name: ______________________________ DOB: _______________ Gender: ______

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:

____

____

____

List three major strengths or abilities you have:

____

____

____

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