A New Life
Christian Counselors

Fieldstone Park
11105 NE 14th Street, Suite 103
Vancouver, WA 98684
Phone: (971) 303-9868
shickman.anlcc@gmail.com

PROFESSIONAL DISCLOSURE STATEMENT 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.

Credentials and Approach to Counseling

Shasta Hickman is a counseling student intern in the M.A. Counseling program at Concordia University, Irvine, California, degree anticipated April, 2019. She obtained a B.S. in Psychology: Pre-Counseling from Corban University, Salem, Oregon. Coursework completed includes training in ethical practice, cultural diversity, human development, pathology diagnosis, neuropsychology, helping relationships, suicide prevention, addiction counseling and intimacy, sexuality, and gender. Licensed Counselors are required to participate in 40 hours of continuing education every two years. As a counseling student intern in a program accepted on the register of the California Board of Behavioral Sciences and practicing in the State of Washington, she will abide by Washington State Code of Ethics as set forth in chapter 18.19 RWC; the laws of the State of Washington; and the American Counseling Association Code of Ethics.

Shasta 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 an evidenced based therapeutic approach which includes attachment therapy (looking at past attachments in relationships and how they affect current situations) and emotion focused therapies. 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 Washington Department of Health (DOH), 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 DOH and to have the DOH confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the DOH;
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. Shasta is supervised by Breanna Jeffries, LMHC. Breanna may be contacted directly at 206-992-0750. 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 18th

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.

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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.

_____	_____
Date	Client/Guardian Signature
_____	_____
Counselor Signature	Client/Guardian Signature

INTAKE FORM

Today's Date: _____/_____/_____

Personal Information

Name:			Age:	DOB: / /
(Circle All that Apply): Single Dating Married Separated Divorced			Cell Phone #: ( ) -	
Address:			Home Phone #: ( ) -	
City:	State:	Zip:	Work Phone #: ( ) -	
# of Children:	Their Ages:		Email:	
Current Partner's Name (If Applicable):			Their Phone #: ( ) -	
Nearest Relative Living Separately:			Their Phone #: ( ) -	

Education / Employment Information

Last grade completed in school:	Are you employed now? _____Yes _____No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

Spiritual History

List a Few Words to Describe Your Personal Faith:
List Those Who Support You Most Spiritually:

General Information

How did you hear about us?
Briefly describe problems you want help with:
How much have you worked during the past two years? Part Time Full Time Other:
Describe your education (# of years of school, special training, etc.):

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.):

Please list/describe any previous counseling experience(s):

Did anyone in your family die before you were 18 years old? Yes No Who?

How old were you? _____ Other family deaths?

When were you last examined by a physician?

Present physician's name:

Phone number:

List any medications you are now taking (prescription and nonprescription):

List any major health problems for which you have received treatment:

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

	SELF	FAMILY
HEART PROBLEMS	_____	_____
CANCER	_____	_____
NERVOUS BREAKDOWN	_____	_____
STROKE	_____	_____
CHRONIC ILLNESS	_____	_____
ALCOHOL OR DRUG ABUSE	_____	_____
LEGAL PROBLEMS	_____	_____
LEARNING DISABILITY	_____	_____
DEPRESSION	_____	_____
OTHER _____	_____	_____

List everyone currently living in your residence, including family and other:

NAME	AGE	RELATIONSHIP

NAME	AGE	RELATIONSHIP

	YES	NO	DON'T REMEMBER
Have you been abused or assaulted?			
Did you witness abuse between your parents?			
Did you witness abuse between parent and child?			
Briefly describe your childhood:			

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 PROBLEMS	STRESS	WORK/SCHOOL	RELAXATION
HEADACHES	TIREDNESS	LEGAL MATTERS	MEMORY
AMBITION	ENERGY	INSOMNIA	MAKING DECISIONS
LONELINESS	INFERIORITY FEELINGS	CONCENTRATION	EDUCATION
CAREER CHOICES	MARRIAGE/RELATIONSHIPS	HEALTH PROBLEMS	TEMPER
NIGHTMARES	CHILDREN	EATING PROBLEMS	UNHAPPINESS
SEXUAL ABUSE	PHYSICAL ABUSE	BOWEL TROUBLES	BEING A PARENT
MY THOUGHTS	STOMACH PROBLEMS	GAMBLING	BINGE EATING
EATING TOO LITTLE	TOO HEAVY OR THIN	SPIRITUALITY	UNFORGIVENESS

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	**Yes, I Used**	**If yes, age at first use**	**When using, frequency of use (daily, weekly, etc.)**	**How long since last used?**
Tobacco					
Alcohol					

Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Meth/Amphetamine/Speed					
Hallucinogens (LSD, Mushrooms, etc.)					
Coffee					
Other					

Please circle any of the following strengths you have:

CONFIDENT HARD WORKER ORGANIZED GRACIOUS SYMPATHETIC DEPENDABLE
SENSITIVE LOGICAL LOYAL GOOD LISTENER DECISIVE
UNDERSTANDING RESPONSIBLE PATIENT SENSE OF HUMOR
OTHER

Please add any additional information which you feel may be helpful to me:

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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, 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

_____	_____
Shasta Hickman, Intern	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, Intern Date

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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
Below $1700	$10
1701- 2100	$14
2101- 2500	$18
2501- 2900	$22
2901- 3300	$25
3301- 3700	$28
3701- 4100	$32
4101- 4500	$35
4501 & Above	$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 Shasta Hickman
(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 Shasta Hickman 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 Shasta Hickman or Breanna Jeffries without such discussion affecting the level of my current care with Shasta Hickman.

In such situations where I, Shasta Hickman, 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 _____