A New Life
Christian Counselors

Fieldstone Park
11105 NE 14th Street., Suite 103
Vancouver, WA 98684
Phone: (360) 558-3705
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PROFESSIONAL DISCLOSURE STATEMENT FOR Valinda Harlan LMHC, NCC

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: I take an eclectic approach utilizing various approved theoretical modalities depending on the individual client and their issues and goals. If you have questions about my procedures, or at anytime you feel uncomfortable, we should discuss your concerns whenever they arise. If you feel we are not a good fit, or are unsatisfied with my services, or if I feel you would be best served by another person, I will refer you to another service provider or a mental health professional.
Counseling has inherent benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.
I practice under the code of ethics established by the American Counseling Association

CLIENT RIGHTS: As a client, you are rightfully entitled

1. To expect that the staff has met the minimal qualifications of training and experience required by state law;
2. To examine public records maintained by the State and to have the State confirm credentials of staff;
3. To obtain a copy of the Code of Ethics, Oregon Revised Statutes (ORS), or Washington Administrative Code (WAC);
4. To report complaints to the proper authorities (i.e. WA State Department of Health; American Counseling Association)
5. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving these services;
6. To obtain permission to view your file, by way of written request stating reason(s) to the therapist
7. 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:
    1. Reporting suspected abuse of a child, developmentally disabled person, or a dependent adult;
    2. 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;
    3. Reporting information required in court proceedings, or by client's insurance company, or other relevant agencies;
    4. Student consultation or supervision;
    5. Defending claims brought by client against therapist;
    6. 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.

EDUCATION: I have a Masters in Professional Counseling, I am a Licensed Mental Health Counselor, a National Board Certified Counselor, a member in good stand with the American Psychological Association and American Counseling Association. I have counseled at Southeastern University Counseling Center and New Directions Counseling. I have been an instructor teaching in the Southeastern University Psychology Dept.
I worked as a Family Pastor for 20 years and I have received instruction as a Pastoral Counselor through Hosanna Ministry. I am a trained Parenting Instructor and I have led seminars, classes, and written curriculum on parenting. I am a Certified Pre-marriage and Marriage counselor through Prepare/ Enrich, and I have been trained by WPATH to address gender issues, and I have written curriculum and led workshops on healthy sexuality.

I am a licensed counselor with the Washington State Department of Health (#LH 60862717) and a National Board Certified Counselor #308374

In accordance with Washington and Oregon 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 both state departments' 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 pastoral and counseling fields.

FEES: My fees for individual and couples therapy are $110 per session for a typical 50 minute session, longer session are available at the same rate (ex $220 for 100 minutes).
Being late to an appointment will reduce the length of the session, it will not change the ending time. Payment is due in cash, check, credit or debit at the beginning of the session. Services will not continue if there have been multiple cancelations or if payment can not be made. If you are not able to keep appointments or make payments, I will no longer be obligated to keep you as a client and I will refer you to services that are better suited for your situation.

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.

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.

Parents & Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right certain information. It is my policy to request an agreement from parents that they agree to give up any rights to access to your records (see below). If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete.
I _____ and _____, as the custodial parent(s)/ guardian, give my permission for _____ to be counseled by Valinda Harlan. I give up my right to access any and all counseling records.
Signature(s): _____ , _____ date:_____

My signature below signifies that I have read and understand the above Informed Consent and I agree to be Valinda Harlan's counseling client under the conditions of the above. I understand that it is my responsibility to make full payments at the time of each session.
_____*I agree to pay a $55.00 first-time Late Notice Fee, and $110 second- time Late Notice Fee if I cancel or reschedule with less than 24 hour's notice.*

Client: Print Name_____

Signature_____ Date_____

Spouse (only if couple counseling): Print Name_____

Signature_____ Date_____

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Intake Form for Clients of Valinda Harlan LMHC, NCC

Name:_____ Today's Date_____

Age_____ DOB_____ Gender_____

Address_____

City _____ State _____ Zip _____

Home Phone (_____)_____OK to leave a message? ___Yes ___ No

Cell Phone (_____) _____ OK to send a text? ____Yes ___ No

Email _____

Occupation _____ Employer _____

Relationship status (check all that apply):

___Single/never been married ___Single/divorced ____Married ____Dating ___Cohabitating ____Widow/Widower other: _____

Name of Spouse/Partner_____

How long have you been Dating? _____ How long have you been married? _____

Relationship satisfaction (circle one)? I don't know low medium high very high

Children: names, ages, (birth/adopted/step) _____

_____

Previous marriages/significant relationships_____

Parents married or divorced?_____ Remarried/step parents?_____

Emergency contact:_____ Relationship:_____

Phone (h) _____ (c) _____

Address _____ City _____State ___ Zip _____

Do You Smoke?_____How Much?_____Do You Drink?_____ How much/often? _____

Do you take recreational drugs?_____If yes, what kind? _____How often?___

Last Medical Examination_____Reason_____

Are you now under a Doctor's Care?_____Reason for Doctor's Care: _____

Are you taking any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have you ever been hospitalized for a major physical Illness/accident? If yes, please describe: _____

_____

Have you ever been diagnoses or hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, depression, etc? If yes, please describe: _____

_____

Spiritual/ religious history/affiliation:_____

How important is it to you to incorporate your spirituality/prayer/scripture into counseling? (Circle one) I don't know low medium high very high

Do you have a family or personal history of substance abuse/addiction? ___Yes____No

If yes, please give brief description: _____

_____

Do you have a family or personal history of phys./emot./sexual abuse?____Yes ____No

If yes, please give brief description: _____

_____

Have you had any previous therapy/counseling? ____Yes ____ No

If yes, give brief reason and outcome/reason for ending: _____

_____

What is the main issue or concern that brings you into counseling?

_____

_____

_____

What do you wish to achieve?_____

_____

_____

How committed are you to changing (circle one of the following):

I don't know low medium high very high

Check Any of the Following That May Apply to You:

	Depressed mood		Anxious Feelings		Difficulty with friends
	Low self-esteem		Feel Tense/panicky		Social fears
	Self-loathing/hatred		Always Worried		Manic/hyper episodes
	Suicidal thoughts		Fears and/or Phobias		Gambling issues
	Suicidal action/attempts		Obsessive thoughts		Anger issues
	Self-harm/cutting		Compulsive acts		Binge / over-eating
	Feelings of hopelessness		Unable to Relax		Restrict eating/induce vomiting
	Always Tired/over sleeping		Insomnia		Bad home/living conditions
	Feel "stuck" /dissatisfied		Drugs/ Alcohol issues		Past/current abuse or trauma
	Teary/ emotional		Recovering addict/ alcoholic		Grief/loss
	Unable to have good time		Low emotional expression		Financial concerns
	Recurrent nightmares		Relationship issues		Job concerns
	Significant weight loss/ gain		Sexual issues		Parent-child concerns
	Hear/see things		Gender distresses		Family issues
	Difficulty making decisions		Sexual orientation concerns		Other:

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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 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 Valinda Harlan, 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. (client name)

Client:_____Dated_____, 20____
(signature)

Counselor:_____Dated_____, 20____
(signature)

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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 Valinda Harlan, 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 number

_____	_____
Signature of Client	Date

_____	_____
Valinda Harlan, LMHC	Date