heartofthecity
http://theheartofthecity.org

The Heart of the City
28925 SW Boberg Rd.,
Wilsonville, OR 97070
Phone: (347) 709-2021
Email: neguscounseling@gmail.com

PROFESSIONAL DISCLOSURE STATEMENT FOR WORKU NEGUSSIE

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 am an intern Counselor who is a Christian but I seek to value the diversity, worldview and belief of each person. Counseling is based upon the understanding that every person, family, and group possesses within themselves the unique strengths and abilities they need in order to overcome the issues that confront them. My job as an intern Counselor is to support you in realizing your potential and overcoming the barriers that stand in the way of you becoming your most actualized self. I place an emphasis on overall well-being, and view each individual and family as a piece of a larger system within which they experience life. I will work with you to identify the underlying issues that may be getting in the way of your well-being and growth and together we will work to address these issues. I believe that each person and family with whom I work has the capability to address their own needs, my work is to support you in recognizing and enhancing this capacity.

The core components in Heart of the City counseling services are: social justice, dignity and worth of the person, the importance of relationships, integrity, and competence. These core values will be woven throughout our work together. I utilize a strengths perspective when working with clients and will work with each client to identify the best approach for their individual situation. Through the therapeutic process, we will work together to set goals and determine steps to be taken to achieve those goals. Overall, the goal for therapy is that each client finds solutions, heals pain, and is able to move forward in their life with confidence and purpose.

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 and by the State of Oregon.

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);
- To report complaints to the proper authorities (i.e. OR State Department of Health);
- 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,

LIMITS OF CONFIDENTIALITY

- 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: As an Intern Counselor, I am currently working towards a Master of Arts from Multnomah University. I have completed all required coursework up until this point, and will be graduating in December of 2018. I also hold a Bachelor of Science degree in Mechanical Engineering from Addis Ababa, University (Ethiopia).

SUPERVISION: As an Intern Counselor, I am actively being supervised by Breanna Jeffries, LMHC. As such, there may be times that Breanna may participate in sessions directly, or be involved in giving me professional direction or guidance in between sessions. Breanna may be contacted directly at (503) 928-6510.

VIDEO TAPING: For the purpose of supervisory review, I (the counselor) 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.

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, except initial "intake" sessions and some couples and family sessions, which are 75 minutes long and billed at 1.5 times the session amount. Group fees are $10-$35 per participant each 90-minute session, depending on group size, topic, and if necessary, financial difficulty. 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 Washington County at 503.291.9111 or 1.800.273.8255, Multnomah County at 503.988.4888 or 1.800.716.9769, or Clackamas County at 503.655.8585, or call 911.

ACKNOWLEDGEMENT OF RECEIPT: I/We, ____, have read and fully understand the information provided to me by Worku Negussie in his Professional Disclosure Statement.

____ ________________

Client/Guardian Signature Date

____ ________________

Client/Guardian Signature Date

____ ________________

Counselor Signature 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 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 HoC. 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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REDUCED FEE SCHEDULE

HoC'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 A New Life Christian Counseling) 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 Worku
(Client Name)
Negussie is masters level student intern counselor at A New Life Christian Counseling, under the supervision of Breanna Jeffries, LMHC (License #LH60336941). As such, he 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 his professional development.

While every effort will be made by Worku to provide competent, skilled and professional care each session, I understand that there still may be limitations to his 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 Worku Negussie or Breanna Jeffries without such discussion affecting the level of my current care with Worku Negussie. In such situations where I, Worku Negussie, 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 ___________________

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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 Heart of the City (HoC), 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 Worku Negussie, that they make 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.

Signature of Client: ____ Dated _________________, 20____

Signature of Counselor : ______________________________________ Dated ________________, 20____

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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

______________________________ ____________________

Worku Negussie, Intern | Date