A New Life
Christian Counseling
A New Life Is Possible One Step at a Time
www.anlcc.com

Vancouver:
201 NE Park Plaza Drive., Suite 293-L
Vancouver, WA 98684
Phone: (360) 980-7906
Fax: (360) 326-1859

Portland:
9727 NE Sandy Blvd., Suite 374
Portland, OR 97220
Phone: (503) 753-4440
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PROFESSIONAL DISCLOSURE STATEMENT FOR BRAD L. PETERSON

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 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 professional counselor, it is my endeavor to utilize various approaches and techniques in order to best serve the needs of the client. I believe that in order for progress to be made in therapy, one must find a sense of meaning and purpose for their lives, as well as find practical strategies and skills for working 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 particular approach or technique.

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 American Association of Christian Counselors; by the WA State Administrative Code for Domestic Violence Perpetrator Treatment Staff; and by OR State Revised Statutes for Licensed Professional 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; American Counseling Association; American Association of Christian Counselors, etc.);
- To be informed of the cost of professional services before receiving these services; including your right to a reduced fee schedule and additional 30% discount for attending Eastside Church regularly.
- 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;
    - 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.

<u>EDUCATION</u>: My education includes a Masters of Arts in Counseling from Western Seminary, as well as a Masters of Arts in Pastoral Studies Degree from Multnomah Biblical Seminary. I also hold a Bachelors of Science in Biblical Education Degree from Multnomah Bible College.

I am a registered counselor with the Washington State Department of Health (#020701 RC00045121) and a certified Supervisor with the Washington State Department of Social and Health Services Domestic Violence Perpetrator Treatment Program. I have received specialized training in anger management, crisis counseling and suicide prevention, men's issues, spiritual integration, and premarital and marital counseling.

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.

<u>FEES</u>: Group fees are $15-$35 per participant each 90-minute session, depending on group size, topic, and if necessary, financial difficulty. Group intakes are typically $50, unless otherwise mentioned. My fees for individual therapy are based upon a sliding scale for the amount of time spent or reserved, at the rate of $35 to $85 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. Rates and payment arrangements will be determined at the time of scheduling.

<u>CANCELLATION POLICY</u>: 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.

<u>EMERGENCY SERVICES</u>: If in need of emergency services, the client should call a crisis line in Multnomah County at (503) 988-4888 or 1-(800) 626-8137 or (503) 215-7082, or Clark County Crisis Line at 360.696.9560 or 1.800.626.8137, or call 911.

<u>ACKNOWLEDGEMENT OF RECEIPT</u>: I/We, ____, have read and fully understand the information provided to me by Brad L. Peterson, MA in his Professional Disclosure Statement.

_______________________________________ ____________________

Client/Guardian Signature Date

____

Client/Guardian Signature

_______________________________________ ____________________

Brad L. Peterson, MA Date

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IMPORTANT INSTRUCTIONS FOR FILLING OUT FORMS

Welcome to A NEW MAN Abuse Prevention Program. Your Intake Counselor will be with you shortly. Please use the time now to fill out the following forms. Please use a pen (not pencil) to fill out the forms.

These questions and forms are necessary for you to complete in order to fulfill the WA State Administrative Code for Certified Domestic Violence Treatment. Answering them accurately is also helpful to provide you with the best treatment experience possible. The more we understand about you, your history and your individual situation, the more we will be able to help you. However, if you find some of the questions too uncomfortable, feel free to skip them for now and we can address them during the interview.

These forms take time and effort on your part. Completing them outside of your interview time will enable you to finish your interview with your counselor in the time allotted. Please have any specific questions from these forms ready to ask your Intake Counselor.

Thank You.

A New Life
Christian Counseling

DV 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:		Msg. Phone #: ( ) -	
Current Partner's Name (If Applicable):			Their Phone #: ( ) -	

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

NAME	AGE	RELATIONSHIP
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

Name of Person(s) Who Introduced You to Christ:	Age at Conversion:
List a Few Words to Describe Your Personal Faith:	
List Those Who Support You Most Spiritually:	

General Information

Briefly describe incident that resulted in referral to DV Treatment: ________________________________

____

____

Please list your original charge(s): ____

Please list any amended/plea bargain charge(s): ____________________________________

PLEASE TURN TO PAGE TWO

INTAKE FORM, Page 2

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 circle any of the following strengths you have:

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

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 add any additional information which you feel may be helpful to us: ___________________________________

____

____

____

____

THANK YOU FOR FILLING OUT THIS FORM

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Portland Office Location:
Office Fax: (503) 296-2071
Eastside Foursquare Ministry Campus
9727 NE Sandy Blvd., Suite 374
Portland, OR 97220
Robyn Honeycutt: (503) 545-7846
Jay McCall: (503) 548-7737
Brad Peterson: (503) 753-4440
Patricia Vann: (360) 936-6876

Vancouver Office Location:
Office Fax: (360) 326-1859
Park Tower Addition
201 NE Park Plaza Dr., Suite 293-L
Vancouver, WA 98684
Greg Goostree: (360) 773-4715
Brad Peterson: (360) 980-7906
Sara Pirolo: (360) 980-4436
Patricia Vann: (360) 936-6876

RELEASE OF INFORMATION

I, ____ ___________________, hereby authorize **A New Life Christian**
Name of Client D.O.B.
Counseling and its registered agents/staff to release and/or accept information regarding me to/from:

____
Name of Person/Agency (i.e. Medical Dr., Attorney, Probation Officer, Pastor, other treatment center, etc.) to give/receive records

Address (if known): ____

Phone: (_____) _________-___________________ Fax: (_____) ___________-__________________

I specifically authorize the disclosure of information and/or records regarding (Please initial each category):

_____ Yes _____ No Evaluation/Assessment Results & Recommendation(s)

_____ Yes _____ No Police/Arresting Incident Reports

_____ Yes _____ No Domestic Violence/Abuse Prevention Treatment Progress

_____ Yes _____ No Legal/Criminal History

_____ Yes _____ No Sexual Addiction Recovery Treatment Progress

_____ Yes _____ No Alcohol/Drug Treatment/Counseling History

_____ Yes _____ No Mental Health Services/Counseling History

_____ Yes _____ No Medical/Psychiatric Treatment History

_____ Yes _____ No Financial Payment Arrangement(s)

_____ Yes _____ No Other _________________________________

_____ Yes _____ No Other _________________________________

This authorization shall be valid for a period of twelve (12) months from the date signed. I understand that I may revoke this release at any time by submitting a written request, but that such a request will not apply to any information exchanged prior to the date of such a request being received.

Signature ____ Date _______________

Parent or Guardian ____________________________________ Date _______________

Counselor ____ Date _______________

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document __________________ (Agency Staff Person)

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"A New Man" and "A New Woman" Abuse Prevention Programs
WA State Certified Domestic Violence Perpetrator Treatment
Program Supervisor–Brad Peterson, MA: (360) 980-7906
Program Staff–Greg Goostree, MA: (360) 773-4715
201 NE Park Plaza Drive, Suite 293 L
Vancouver, WA 98684
Fax: (360) 326-1859

Release of Information
Victim

I, ______________________________________ Date of Birth _____________
(Client's first and last name)

dated ________________, 20_____ authorize information to be exchanged between the following person and A New Life Christian Counseling (Brad L. Peterson, MA or Greg Goostree, MA) for the purpose of treatment coordination as stated below.

Name of Victim(s):________________________________ Relationship:___________________

Address/City, State: ____

Zip Code: ___________________ Phone: _____________________ Work: ________________

This request and authorization applies to:

Information in accordance with WAC 338-60 requires that state certified treatment programs notify the victim, the victim's community advocates and legal advocates with certain information that includes entry into treatment, termination from the treatment program, and any other information related to victim safety.

Other: ____

____
Signature of Client Date Signed

____
Signature of Witness Date Signed

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WA State Certified Domestic Violence Perpetrator Treatment Program
Program Supervisor–Brad L. Peterson, MA: (360) 980-7906
Program Staff–Greg Goostree, MA: (360) 773-4715
201 NE Park Plaza Dr., Suite 293 L
Vancouver, WA 98684
Fax: (360) 326-1859

A New Man Abuse Prevention Treatment Program Contract

1. **Treatment Requirements**

- Understand that our program philosophy is based upon:
  1) The victim may not be blamed for the participant's abuse
  2) The perpetrator must stop all forms of abuse
  3) An abuser is to be held accountable for the abuser's actions
  4) The program's primary concern is for the safety of victims.

- To Complete Treatment (Exit Criteria):
  1) Complete both Phase 1 and Phase 2 requirements (see below).
  2) Cooperate with all program requirements in this contract, as well as additional requirements that may be introduced during the treatment period.
  3) Stop any/all physically violent and threatening behaviors.
  4) Awareness and decrease of other forms of abuse, including controlling behaviors, while a client.
  5) Demonstrate ability to be non-abusive and non-controlling in relationships.
  6) Develop and adhere to a Responsibility and Action Plan.
  7) Comply with court orders, other treatment conditions, and programs (i.e., Work Crew, Electronic Home Confinement, Work-Release, Substance Abuse Treatment, No Contact Orders, etc.).
  8) Sign all required releases of information.

- Phase 1 Requirements
  1) Complete a minimum of 26 weekly group sessions.
  2) Submit 25 journals.
  3) Read the treatment book twice and provide proof of completed assignments.
  4) Report at least 10 consecutive and ongoing weeks of non-abusive behavior.
  5) Submit and pass an appropriate Letter of Accountability/Continuing Accountability Plan.

- Phase 2 Requirements
  1) Complete a mutually agreed upon schedule of group or individual sessions or combination of both not to be less than 6 monthly group sessions.
  2) Control Journal(s) and/or Abuse Intervention Sheet(s) as needed/required by facilitator.
  3) Keep Responsibility and Action Plan up to date.

_______ Client's initials

2. **Attendance & Makeup Sessions**

- Sessions are offered on a weekly basis with the minimum treatment consisting of 26 weekly sessions followed by a minimum of 6 monthly sessions. **Both of these periods are determined between client and counselor, based upon the client's group participation and ability to apply treatment in outside relationships.**
- You are responsible for maintaining consistent attendance, including selecting one group time that works best for you and making necessary adjustments to your work and personal schedule; securing adequate and reliable transportation to/from group; and making up missed groups within one week. **Inability to maintain at least 50% attendance may result in dismissal from program.**
- You are expected to attend weekly group sessions and are **allowed 2 excused absences during Phase I** to be used at your discretion. Additional absences for any reason (except for medical/family emergencies; court-mandated treatment, hearings, or incarceration; or inclement weather) will be considered unexcused.
- If you miss group unexcused, you will be charged your normal fee for the missed group, payable at the next group, unless you make up the group within one week of the absence.

- "Make up" sessions under these conditions are charged an additional $5 group switch fee, payable at the time of the makeup session. Clients are not allowed to attend makeup sessions without full payment.
- Clients may attend a maximum of two groups per week and total group sessions may never exceed number of weeks in the program, unless "doubling up" on sessions prior to a no-contact order hearing. All additional sessions under these conditions would be in addition to the 26 required weekly sessions in Phase I.
- Clients may attend any of the regular group session times offered throughout the week to makeup an unexcused absence, prior to their next scheduled group session.
- If you arrive more than five (5) minutes late for your session, you will only be admitted at the discretion of the group leader.
- You must notify your group leader within 24 hrs. after your missed group time when an emergency prevents you from attending group. The leader will determine if your reason is judged to be an emergency. If deemed an emergency, please provide documentation of proof upon your return.
- If you are going on vacation or will otherwise have a pre-planned absence, please give your leader a note with your name and exact dates that you will be missing the group, as well as your date of return to group.
- You must be clean and sober the day of the group or you will be asked to leave the group without a refund. This session will be considered an unexcused absence.
- On any phone messages please leave a return phone number. Most business should be taken care of before or after group. Adequate time is given after the end of group to do so.

3. Financial Terms and Conditions

Fees are as follows:

Intake/Assessment Fee	$50
Group Session Fee	$30
Treatment Manual & Program Materials	$20
Additional Individual Session Fee	$50/hr

- You are responsible for making consistent payments for services rendered.
- This is a "fee for service" program whereby you are receiving a service for a fee. Fees are due when the service is provided, unless prepaid.
- Clients who attend session without payment are expected to make payment before/at their next session. Failure to make up a missed payment under these conditions will result in suspension (not allowed to attend w/o payment) from the program. Absences due to suspension do not require payment. Three consecutive absences, due to inability to pay for services, will result in dismissal from the program.
- Payments may be made with cash, money order, cashier's check, or personal check in the exact amount of fee for service. **Please makes checks payable to: *ANLCC* or to: *A New Life Christian Counseling.***
- There is a return check fee of $15 (due upon receipt) in the event of a NSF/Returned check.
- If cash payment is greater than the fee, the balance will be credited towards future fees, if no "change" is available.

_______ Client's initials

4. Confidentiality

- A Release of Information must be signed by the client as a condition of treatment to cover all agencies, legal entities, and relevant others involved in your case. These contacts may be consulted both during intake and during treatment.
- You are required to maintain confidentiality of group members, including their identity and personal, identifying information about them.
- This program may audio or video tape group sessions only when all participants grant written consent that gives details about the specific use(s) for the tape. We will obtain an additional consent statement from each participant to permit use of the tape for any purpose other than the purposes specified in the original consent.
- As required by Washington State Law, your right to confidentiality has the following limitations:
    1) Apparent danger to self or others or grave disability as a result of a mental disorder will be reported to the County Designated Mental Health Professionals.
    2) If reasonable cause exists to suspect child abuse, a report will be made to Child Protective Services.
    3) Threats made against a specific victim are reported to that person and the police.

_______ Client's initials

5. **Administrative Requirements**

- Report any changes to your address and/or phone number(s) to your facilitator **in writing**.
- Make and keep copies of all contracts, letters, notices, journals, letters, as well as any payment receipts as verification of your attendance and participation.
- Be prepared each group with your Treatment Folder, extra paper, and a pen or pencil.

_______ Client's initials

6. **Reports**

- Reports regarding your attendance and progress are sent monthly to the referral source.
- Copies of monthly reports, or up-to-date progress reports, are available upon request at group sessions.
- **Special letters, or progress reports requested outside of group sessions, will be charged a $15 fee**, payable at your next session. You must pay an additional consultation fee ($50/hr.) for any individual time required to develop this report that exceeds 15 minutes.

_______ Client's initials

7. **Group Use of Building**

Our office is shared by other service professionals, therefore respect and courtesy towards the building, its grounds, its tenants, and other clients and occupants is requested.

- All outside entry doors lock at 6 PM. After 6 PM, you will be let in by the group facilitator at the West entrance (under the skybridge) just prior to the group's start time.
- If you smoke, please smoke in your car or in the outdoor smoking area in the circle driveway beyond the East entrance to our building and dispose of all butts and other litter properly.
- If you arrive more than 15 minutes early, please wait in your vehicle or quietly in one of the waiting areas near your conference room. Please take care to not disturb other tenants or clients.
- No Bicycles, muddy boots/shoes, or excessively smelly or dirty clothing allowed in building. Please take precaution to carry extra clothing and shoes, if necessary, as well as a bike lock, if riding a bike.
- No FOOD is allowed in group room. Beverages are permitted unless causing a distraction.
- Please silence your CELL PHONE upon entering group room and discreetly leave the room during group if you must answer an emergency call. **Any use of cell phone or texting during group is highly discouraged.**
- Please be courteous and respectful of others in building when entering/leaving building by not crowding or conversing in hallways, doorways, or stairwell.

_______ Client's initials

8. **Session Length**

- Group sessions are 90 minutes.
- You will not receive credit for a missed group or any group attended less than 50% (45 minutes).
- Individual sessions are 50 minutes.

_______ Client's initials

If you re-offend during the course of your treatment you will be required to start the program over from the beginning.

I have read and understand the terms and conditions of the treatment contract. I agree to abide by these standards. I also understand that any attempt to distort relevant material will be grounds for dismissal from treatment. I also understand that my program standards are set to meet the state requirements of WAC 388.60-140 which takes precedent over any terms and conditions of the treatment contract.

_____________________________________ _____________

Client Signature Date

_____________________________________ _____________

Witness Signature Date