

**Nichole Hoffman, MS NCC**

**Friends of the Family Ministries  
Child and Family Therapist**

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### **Professional Disclosure Statement**

#### **PHILOSOPHY AND APPROACH:**

I believe people are faced with difficult changes throughout life's journey. These difficulties bring people into a state of confusion. Relationships, like the one we are entering into, help to smooth this road out and allow you and your child to deal with life challenges. I see clients as equal partners in the counseling process, and strive to make the counseling relationship positive, encouraging, and safe. Parents know their children better than anyone and therefore are part of the process. You, as parents, help gain understanding of your child and partner together to develop and incorporate positive plans leading to success. The goal is for you and your child to gain healthy relationships and a positive self-concept.

As a counselor, I use a variety of methods. My focus with children is a combination of direct and non-direct play therapy combined with art. I include parents and children in making positive plans to encourage behavioral changes. I also help guide parents in using constructive language at home in order to produce therapeutic goals.

Parents are in control of this relationship. You may choose to end our counseling relationship at any time. I will be supportive of that decision.

#### **CREDENTIALS:**

I hold a Masters of Science degree in Counseling from Oregon State University. I am currently a nationally certified counselor. I have been trained in non-directive play therapy as well as educated in many counseling techniques. I am a licensed school counselor and have had experience in schools K-12 as well as in community settings. I have experiences working with children from 3 to 19 and enjoy people of all ages. I have three children ages 6, 4, and 1 ½ years old. I also work with our church high school youth group serving young women.

I am not a Licensed Professional Counselor (LPC) nor am I a registered intern working toward this. I will not assess and assign mental health diagnosis. This is not the intent of our relationship. If you are interested in seeing a LPC or someone who can diagnose a mental health illness please ask for referrals.

#### **COMMUNITY:**

Counseling works best when your counselor can be completely objective therefore, I refrain from having social relationships with people that I work with professionally. This can be tricky if you see me in the community, especially working with children. I have a standard policy that I do not approach adult clients if we run into each other in the community. However, with children it may feel like rejection. We can work together to make this work. If I see you with your child in the community I will acknowledge and say hello. If I see you alone in the community I will not approach you in order to avoid discomfort. However, if you see me and wish to speak to me, please feel free to come and say hello. Of course, confidentiality still applies; therefore, I will refrain from discussing counseling topics during these kinds of encounters.

#### **SCHEDULING AND FEES:**

Sessions are typically 50 minutes and are scheduled appropriate for the goals and needs of the

client. I will give an estimate of the number of sessions needed after our initial one or two visits, when we have a better understanding of your goals. The fees are based on a sliding scale ranging from \$35 to \$80, and are negotiable. Gross income and number of dependents are factors in determining this fee. Individual and family sessions are considered the same as individual sessions. I am not a state-licensed counselor and therefore my services are not normally covered by a client's insurance.

**Payment:** Fees are payable at the time of service.

**Cancellations and no-shows:** Your regular fee will be charged for no-show appointments, or for those canceled with less than 24 hours notice.

### **RIGHT TO PRIVACY/CONFIDENTIALITY**

All communication between the client and counselor becomes part of the clinical record. Records are the property of Friends of the Family Ministries in accordance with legal requirements, adult client records are disposed of seven years after the file is closed; minor client records are disposed of seven years after the client's 18th birthday.

While most communication between a client and counselor is confidential, the following limitations and exceptions do exist:

- The counselor determines the client is a danger to himself or someone else.
- The client discloses abuse, neglect or exploitation of a child, elderly or disabled person.
- The client authorizes the counselor to release records.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose information. /

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. You have agreed that your counseling fee will be \$\_\_\_\_\_ per session. If at any time your fee becomes a problem, you will discuss it with me during our session. By your counselor's signature, Friends of the Family Ministries verifies the accuracy of this statement and acknowledges our commitment to conform to its specifications.

Client or  
Guardian  
Signature: \_\_\_\_\_ Printed  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor  
Signature: \_\_\_\_\_ Printed  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT FOR COUNSELING OF MINORS

Name of Parent/Guardian \_\_\_\_\_

Name of Minor \_\_\_\_\_

Minor's Date of Birth \_\_\_\_\_

Name of Counselor \_\_\_\_\_

This is to certify that I give permission for Friends of the Family Ministries for treatment of my child. This counseling may include individual, family, or group counseling. This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation, if necessary.

I hereby waive my right as a parent to obtain information from and copies of any records from Friends of the Family Ministries pertaining to the evaluation and treatment of the following child: \_\_\_\_\_, age \_\_\_\_\_. I understand that Friends of the Family Ministries *may* refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's counseling relationship, if disclosure in the opinion of the child's therapist would negatively impact the child or the child's progress. I hereby release Friends of the Family Ministries from any and all liability for good-faith refusal to disclose the child's information or records.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact (Other than yourself):

Name \_\_\_\_\_ Phone \_\_\_\_\_

Witness/Title/Date \_\_\_\_\_