KALOS
COUNSELING

Welcome!

Included within this packet you will find information about my practice, fees, and other important details as you begin the counseling process. Please take the time to read over each of the sections, and print this out for your first appointment. I sincerely look forward to being of assistance to you and/or your family.

Warmly,

Katherine L Hammons, LPC

*As starting counseling is a big decision and you may have many questions. I will do my best to answer any of your questions or concerns as you read the enclosed information. This form explains information about Kalos Counseling, LLC, our policies, State and Federal Laws, and also includes your rights as a consumer of our services.*


## CONFIDENTIAL: Child/Adolescent Intake Form

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FORM TO BE COMPLETED BY PARENT/GUARDIAN

Parent Name_____ Appointment Date _____

Child/Adolescent Name _____Date of Birth_____

Sex_____

This child is currently living with _____

_____

Home Address

(Primary)_____

City _____State _____Zip_____

Secondary Address (if appropriate)

_____

City _____ State _____Zip_____

Phone (H) _____(C) _____ (W)_____

Email (parent) _____

(Email) Child/Adolescent _____

School Currently Attending _____

Grade _____

Please check preferred days and times for your appointment availability:

☐ M ☐ T ☐ W ☐ Th ☐ F ☐ am ☐ midday ☐ pm

Would you like to be provided reminders for future appointments?

☐ Yes ☐ No

If Y, please indicate preference.

Text _____ Voicemail _____ Email _____

Who referred you to Kalos Counseling?

_____

May we send a thank you for the referral?

_____

**REASONS FOR SEEKING HELP (*use the back if you need to*)**

**What are the concerns about your child that led you to pursue counseling?**

_____

_____

_____

_____

Check one: Mild ☐ Moderate ☐ Severe ☐

## MEDICAL HEALTH INFORMATION

How would you rate your child's current health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems).

☐ Yes ☐ No

If yes, please explain

_____

_____

_____

_____

| Medications (over the counter or prescriptive) | Dosage | Reason for Medication | Prescribing Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has your child ever had surgery? If yes, for what reason?

_____

_____

_____

## COUNSELING AND PSYCHIATRIC HISTORY

Are there chemical substance abuse issues in your family? ☐ Yes ☐ No

If yes, who? _____

If clean/ sober, for what length of time?

_____

Has your child ever been hospitalized for mental illness or substance abuse?

☐ Yes ☐ No

If yes, for what specific reason?

_____

Has your child had any previous counseling? ☐ Yes ☐ No

If yes, which type?

_____

Name of Past Therapist/s

_____


# ADOLESCENT COUNSELING INTAKE FORM

## TO BE FILLED OUT BY TEEN (AGES 13-17) AND INCLUDED ALONG WITH CHILD/ADOLESCENT FORM

Name _____ Date of Birth _____

Address _____ City _____State _____ Zip _____

Who are you presently living with? _____

Siblings? Please list names and ages _____

School _____ Grade _____

Hobbies _____

Job _____

(If none, leave blank)

What concerns have brought you into counseling today?

_____

_____

_____

_____

_____


CHECKLIST OF CONCERNS

(to be filled out by Adolescent)

☐ Feeling Accepted by my peers

☐ Learning how to trust others

☐ Feeling bad about the way I look/my body

☐ Getting along with my parents or other family members

☐ Worrying about whether I'm normal

☐ Dealing with sexual feelings and/or problems

☐ Excessive worry or anxiety

☐ Trying to decide on career

☐ Never eating

☐ Eating too much and vomiting to control weight

☐ Dealing with Alcohol or Drug use

☐ Dealing with problems at school

☐ Dealing with how I feel about myself

☐ Concerns about boyfriend/girlfriend

☐ School Stress that feels unmanageable

Are there any other problems or concern you would like to address?

_____

_____

**Checklist for Parent to Fill out Re: Child**

Please indicate severity of your present concerns: ☐ Mild ☐ Moderate ☐ Severe

Please indicate which of the following you are concerned about for your child. Check all that apply:

☐ Lack of Motivation
☐ Excessive fears or anxiety
☐ Feeling lonely
☐ Refusing to respond to authority
☐ Difficulty being away from specific family members
☐ Loss of interest in usual activities
☐ Obsessions/compulsions
☐ Excessive fear of specific places/objects
☐ Getting into trouble at school/play
☐ Difficulty falling asleep/inability to sleep all night
☐ Decreased appetite
☐ Increased appetite
☐ Hyperactivity

☐ Temper Tantrums
☐ Bullying/picking fights
☐ Crying Spells
☐ Angry Feelings
☐ Nightmares
☐ Lack of self confidence
☐ Hearing voices
☐ Friendship Issues
Other: _____
_____
_____

Is there Any other information that would be helpful for your therapist to know that is not covered above? Please feel free to use the back if needed:

_____
_____
_____

CONSENT FOR COUNSELING OF MINORS (AGE 17 & UNDER)

This is to certify that I give permission for the minor named above to permission for the minor named above to participate in counseling.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____


**Contact:**

My main office is located at *56300 Hospital Parkway, Suite 105, Johns Creek, Ga 30097*. I can be reached via phone at 770-225-1456.

**Hours and Dates Available:**

**Fall 2017-Starting Oct 1.**

| | | |
|---|---|---|
| Tuesday | 9-2 | Johns Creek |
| Wednesday | 9-2 | Johns Creek |
| Thursday | 9-1 | Johns Creek |
| Friday | Upon request | Johns Creek |

**Qualifications:**

My formal education includes a Bachelor of Psychology Degree and a Master's Degree in Counseling. I am recognized by the State of Georgia as a Licensed Professional Counselor and have been helping people in the context of counseling relationships for over 15 years.

My early experience includes forensic interviewing and trauma work. I have been qualified and have served as an expert witness in the court setting multiple times. I have been active in the scope of private practice for the last 12 years both in Charleston, SC and the Greater Atlanta area. I completed a year fellowship program with the CS Lewis Institute of Atlanta, and have also serve as a mentor within the organization.


**Approach:**

You can get the most out of our time together if you understand how counseling works and are informed about how I practice. This is an introduction only, and you may feel free to ask questions throughout the time we work together. In counseling I approach clients from an integrative perspective, meaning I apply my Christian Faith with compatible psychological perspectives. I believe we are whole persons, with physical, psychological, social and spiritual aspects. Whether we include the discussion of the spiritual dimension of life in our time together
will be up to you, however, it is important that you are aware that this is my worldview, and it does inform who I am and how I understand others.

I also utilize both Cognitive Behavioral Therapy and Emotionally Focused Therapy as appropriate. Other counseling approaches may be used depending on the individual or situation.

**Expectations:**

Counseling includes both the development of a trusting relationship between us and the development of goals for your situation. Together we will formulate agreed upon plans to accomplish these goals. *Thus, counseling will involve your active involvement and efforts to understand and change your thoughts, feelings and behaviors.* You will be expected to work both in and out of our counseling sessions. Some examples of this may include homework assignments, exercises, writing in a journal or observing yourself outside of the counseling office.

I will enter the relationship with hope and expectation for positive change. It is important however to know there are possible risks as well as benefits to counseling. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger or frustration. You may even notice unexpected difficulties in your relationships with other people. Often, once the dynamics that did not serve you well in the past become recognized and you begin to change, others may find these changes unsettling and even resist your "new, and healthier behaviors". I will always encourage you to bring any of your concerns specific to this matter to your sessions as we progress.


I work with individuals, couples and families. Clients with whom I work are those who I believe I can help. If in my professional opinion, I cannot help utilizing the resources and skills I have available, I will offer a referral to another therapist whom I believe better equipped to meet your needs.

**Confidentiality**

I regard the information you share with me with the greatest respect, and therefore, I want to be clear as possible about how it will be handled. All information that we share, as well as my records of our conversations are confidential. My administrator has signed a nondisclosure form and adheres to our strict confidentiality policies. There are four circumstances in which I am not able to guarantee confidentiality:

1) If child abuse, elder abuse or dependent/impaired adult abuse is suspected, the law requires I report it to the appropriate authorities.

2) If I believe a client presents clear and imminent danger to either themselves or others, the appropriate people will be contacted to prevent harm.

3) In rare circumstances, I may be ordered by a Judge to release information and would be in violation of the law if I did not provide the requested information.

Finally, if I happen to see you outside of our counseling sessions, my policy is not to acknowledge you unless you greet and/or acknowledge me first. This is to respect your privacy as well as expresses my commitment to honor your confidence.

**Minors**:

When consulting with parents regarding minor children, specific content of therapy sessions with children or adolescents are held in strict confidence, *unless the child's welfare requires that the parent (s) have access to such information.* In most cases, joint meetings between children and/or adolescents, the parents and the therapist will be arranged as part of the therapy process.


**Couples Therapy:**

I strongly adhere to a "No Secrets Policy" when doing couples work. If it comes about that an individual provides information to me that the other party should have knowledge of (active infidelity, placing the family at risk etc), I will strongly suggest they share this with their partner. If they would like my help facilitating the information during a follow up couples session, I am happy to do so. If this is not something they are able or willing to do, it is my policy to share the information, as necessary, on a case by case basis.

**Outside Consultation**

In order to provide you with the best possible help, there may be times I consult with other therapists who may have insights that could be of assistance. This will only be conducted in a way that your confidentiality be preserved.

Otherwise, I will not tell anyone anything about your treatment, diagnosis, history, or acknowledge you are a client, without your full knowledge and a signed Release of Information Form.

If there is someone you believe it will be helpful for me to coordinate with, please provide this information during our initial meeting. I will be happy to provide you with the necessary release and will contact them as needed.

**Explanation of Dual Relationships**

Although our sessions may bring about intimate psychological conversation at times, it is important to realize that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with me. You will be best served while I am seeing you for counseling if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You may learn more about me as we work together, but it is important for you to realize you are experiencing me as a professional therapist.

Therefore, because of the nature of a therapeutic relationship, I do not "follow" my clients on Facebook, Instagram or Linkedin, or any other social media sites. I request that they do not "follow me" on any of my personal social media as well.

We have recently established our Kalos Counseling Facebook page and we invite (without any obligation whatsoever) those interested to "follow us", as we often include helpful articles, encouragement and suggestions on a regular basis.

**Email, Text and Phone Contact**

I try to minimize any text or email correspondence for both privacy and confidentiality purposes. I encourage anyone who has important information to share to feel free to do so via email, however, please know beforehand that the information you provide may not be protected, and because of my schedule, feedback will generally be postponed until our next scheduled appointment.
Please contact Kalos Counseling by calling 770-225-1456. Due to other appointments scheduled throughout the business day, my administrator may be equip to answer your questions in a more expedited time frame than I. If you feel the need to speak with me personally, please allow 24 business hours for me to return calls. If your call happens to fall on either a weekend or vacation, I thank you in advance for allowing further time.

**Appointment Reminders**

As a courtesy to you, Kalos Counseling will provide a reminder call the day before each scheduled appointment. We also offer you the option of receiving text or email reminders. The calls will be our confirmation you are scheduled in our calendar. If for some unforeseen reason, you do not hear from us the day prior to your appointment please contact our administrator as soon as possible to ensure any avoidable conflicts.

**If an emergency situation were to happen outside of normal business hours, please call 911 or go to your nearest emergency room.**
**Fee Structure:**

| | | | |
|---|---|---|---|
| **New Intake** | **(90)** | **minutes** | **$185.00** |
| **Individual Session** | **(50-60)** | **minutes** | **$125.00** |
| | **(75-90)** | **minutes** | **$185.00** |

Please note, phone calls past 15 minutes will be pro -rated at my hourly individual rate.


If I speak to you twice in one day and it goes over a 20-minute window combined, I will have to charge for this service.
Preparation for documents provided for legal or other purposes will be charged at the hourly rate.

**Insurance**

We do not file insurance. However, please ask your counselor for a superbill and monthly copies will be provided for clients per their request. This will allow individuals to submit for reimbursement with their insurance company. I provide a sliding scale rate for clients who qualify. I have a few slots available for this option and am happy to provide this as I am able.

Thank you so much for taking the time to read this lengthy introduction. I am very excited to begin working with you!

If these guidelines are acceptable to you, please sign below:

**Signature**_____**Date:** _____


**You may have a copy of this form if requested.**
**PLEASE READ: Form must be filled out by client (or guardian if a minor) to cover fee for canceled sessions with less than 24-hour notice.**

## Credit Card Authorization Form

Counselor: _____

Client(s) Name(s): _____

Credit Card#: _____

Name on Credit Card: _____

Card Type: ☐ MasterCard ☐ Visa ☐ American Express

Expiration Date: _____

Card Verification Code: _____

Billing Address: _____

Zip Code: _____

I agree that the credit card listed above may be charged for the therapy sessions and/or assessments of the client(s) named and therapy sessions canceled with less than 24-hour notice. This form and my credit card information will be held in my confidential client file until all billing has been completed and then destroyed promptly at the end of that time period.

Signature: _____ Date: _____


# Patient Notification of Privacy Rights

I have been provided a copy of, or have been exposed to access and the invitation to receive a copy of my protected Health Care Information via the Healthcare Portability and Accountability Act. (HIPPA) via Kalos Counseling, LLC.

Kalos Counseling, LLC is required to secure your signature indicating you have received access to your own copy or denied the opportunity to be given a copy of the Patient Notification or Privacy Rights Document.

**Kalos Counseling, LLC, / Katherine L. Hammons, LPC**
**HIPPA Compliant Officer**

**Client Name (please print) _____**

This ensures I understand I have the right to review the HIPPA document and it includes a detailed description of the possible uses and disclosures of my protected healthcare information. Signing below indicates I have received a copy or have denied the right to be provided one.

_____ _____
**Client Name** **Date**

_____ _____
**Parent or Guardian Signature** **Date**