Included within this packet you will find the appropriate paperwork to fill out, information about the practice and other important details as you begin the counseling process. Please take the time to read over each of the sections, filling out what is applicable. Once you have done so, please print this material out and bring it to your first appointment. I sincerely look forward to being of assistance to you and/or your family.

Warmly,

Wayne Hulon, M.Div. LPC ABCP

This information explains the practice and policies, State and Federal Laws, and includes your rights as a consumer of services.

Contact: My main office is located at 6300 Hospital Parkway, Suite 105, Johns Creek, Ga 30097. I can be reached via phone at 770-540-0366.

Hours and Days Available: Monday – Friday from 9-7. Saturdays with special needs or upon request.

Policies of the Practice

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 the application of the brain – body relationship, our beliefs and values, our interpersonal style, our psychosocial logical perspectives, and their impact on our behavior. I believe as whole persons, we have physical, psychological, social and spiritual dimensions of our life that significantly impact the quality of our life and healing. I incorporate a variety of psychotherapeutic treatment systems including; DBT, Emotionally Focused Therapy, Client Centered Therapy, Imago Therapy, Cognitive Emotional Therapy, Brain Based or Mindfulness Therapy and Family Systems Therapy, as appropriate. Other counseling approaches may be used depending on the individual or situation.

Expectations: Counseling includes both the development of a trusting, safe, and non judgmental therapeutic relationship between you and I , and the development of goals for your situation. Together we will formulate agreed upon plans to accomplish these goals. Thus, therapy will require your active involvement and efforts to understand and create change in thoughts, feelings and behaviors. You will be invited to work both in and out of our therapy sessions which may include homework assignments, exercises, writing in a journal or watching videos, observing yourself mindfully, or changing behaviors.

I will enter the relationship with positive regard, 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 utilizing a variety of approaches, counseling, psychotherapy, neuropsychotherapy, integrative psychotherapy, and neurofeedback

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 therapy 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 or other behaviors 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 and it, it is my policy to share the information, as necessary, on a case by case basis, particularly if it is life threatening.

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 other professionals, 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 therapy, 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 either. We will be establishing a Facebook page and we invite (without any obligation

whatsoever) anyone who may be 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 me by calling 770-540-0366. Due to other appointments scheduled throughout the business day, my administrator may be more able 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.

Appointments: Building a therapeutic alliance takes time for trust and vulnerability to grow. As you face issues, resistance may express itself in many ways. Typically missed appointments, sickness, schedule conflicts, financial issues are ways in which this resistance appears. For that reason, I will attempt to find a day and time that works consistently as that is necessary to build trust and utilize therapy optimally. It is your responsibility to set, clarify, or cancel appointments as I will if I am unclear or have an emergency:

Cancellations: All cancelations must be made with a 24 hour notice. This time has been set aside for you and if you do not reschedule, for that week or I am unable to fill that time, you will be charged the whole fee. Please note that special consideration will be given in cases of illness or emergency beyond your control.

Charges: Initial intake (90) minutes $185.00 Individual Session (50-60) minutes $125.00

(75-90) minutes $185.00 Couples Therapy (60-75) minutes $130.00

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 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

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 hours 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 Wayne Hulon 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. Wayne Hulon M.Div. LLC , 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

CONFIDENTIAL-ADULT COUNSELING INTAKE FORM

Name_____ Appointment Date _____ Age ____

SS Number_____ Date of Birth ____/_____ /_____

Mailing Address _____

City _____State _____Zip_____

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

Email _____ Please check preferred days and times for appointment availability: M T W Th F am midday pm Would you like to be provided reminders for future appointments? Y or N. If Y, please indicate preference. Text ___ Voicemail ___ Email ___ Who referred you to Wayne Hulon M.Div. LLC?

__

If a professional referred you, may we send a thank you for the referral?

_____

Current Marital Status: Single ___ Married ____ Separated ____ Divorced ____Widowed_____ Spouse's Name _____ Age_____ Years Married _____ Name of Children and/or Step Children and Ages _____ Presently living with: Parents _____ Spouse _____ Roommate_____ Alone_____ Other

Phone Number _____ Permission to contact? Y or N

_____

REASONS FOR SEEKING HELP (use the back if you need to What concerns have led you to pursue counseling?

_____

_____

_____

Where is this impacting you the most? Check all that apply: Home ____Work _____Marriage

When did this begin to be a problem for you? _____

Please rate the severity of your current concerns. Check one: _____Mild _____ Moderate _____ Severe

_____

What do you hope to gain from counseling?

_____

Who is your biggest support at this time and are they involved in helping you with your current concern?

_____

_____

MEDICAL HEALTH INFORMATION How would you rate your current health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam _____ Physician _____ Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems). ☐ Yes ☐ No Describe any physical problem you or a member of your household have which require medical or physical

_____

Medications (over the counter or prescriptive) Dosage Reason for Medication Prescribing Physician Have you ever had surgery, and if so, for what reason? _____

_____

Are there chemical substance abuse issues in your family?

_____

Have you ever been treated for mental illness or substance abuse? ☐Yes ☐ No If yes, for what specific reason? _____

Have you ever participated in counseling before? ☐ Yes ☐ No If so, when and why?

_____

Name of past therapist/s

_____

_____

OCCUPATIONAL AND EDUCATIONAL Occupation? _____

Employer? _____How long? _____ If currently a student, Field of Study _____ ☐ Part Time ☐ Full Time

Circle last year of school completed 9 10 11 12 GED College 1 2 3 4 Graduate/Doctorate Other

_____

Military Service (include years served and dates) _____

RELIGIOUS BACKGROUND Religious Affiliation _____ ☐ Active ☐ Inactive Do you attend a local church? ☐ Yes ☐ No

If yes, name of church: _____

How significant is religion to your everyday life? _____

Please indicate which of the following currently are being experienced as a problem for you.

Check all that apply.

___Under too much pressure, feeling stressed ___ Recent significant weight loss or gain ___Use of alcohol ___ Feeling lonely ___Angry feelings ___ Use of non-prescription drugs ___Concerns about finances ___ Feeling Distant from God ___ Feeling “numb” or cut off from emotions ___ Hallucinations ___ Angry outbursts ___ Inability to concentrate while at ___ Excessive fear of specific places/objects school or at work ___ Difficulty making friends ___ Feeling Driven ___ Crying Spells ___ Nightmares ___

Feeling as if you were better off dead ___ Lacking Self Confidence ___ Difficulty making decisions ___ Loss of interest in Typical Activities ___ Loss of interest in sexual relationship ___ Inability to control thoughts ___ Feeling sexually attracted to members ___ Feeling trapped in rooms/buildings of your own sex ___ Hearing Voices ___ Concerns about physical health ___ Blackouts or loss of memory ___ Loss of appetite/increased appetite ___ Sleeping too much/too little ___Lacking self-confidence