Counseling Services Stacey O. Kitchens, LLC
Stacey O. Kitchens LPC, NCC
4139 Baker Street, Suite #16
Covington, GA 30014

CLIENT / PARENT INFORMATION & REGISTRATION INFORMATION:

CLIENT NAME OR <u>IF UNDER 18</u> PARENT/ADULT: _____

DATE OF BIRTH: _____ SS# _____ SEX: MALE FEMALE

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

EMPLOYMENT STATUS: Employed Retired Unemployed Student (part time / full time)

Level of education: _____ EMPLOYER: _____OCCUPATION:_____

RELATIONSHIP/MARITAL STATUS: Single Married Divorced Separated Widowed

PARTNER/SPOUSE/ PARENT NAME: _____ DOB: _____

DATE OF BIRTH: _____ SS# _____ SEX: MALE FEMALE

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

EMPLOYMENT STATUS: Employed Retired Unemployed Student (part time / full time)

Level of education: _____ EMPLOYER: _____ OCCUPATION: _____

CHILD/REN NAMES (If the client, please place an * beside the child's name IF the child is the patient):

Name: _____Sex: ____ Birthdate: _____ Age: ____Living with you? _____Grade: ____ School:_____

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What is the reason for your appointment today?
(problems and concerns) _____

_____

What do you wish/hope to accomplish by coming to therapy? _____

_____

MEDICAL HISTORY: Please list any medical conditions:

_____

_____

Please list any medications you are taking:

_____

_____

Who is your Primary Care Physician (PCP)? _____ Phone #: _____

Insurance Companies encourage my office coordinate benefits and treatment with your PCP.
With this, may we contact your PCP? Yes No

How many psychotherapists / counselors have you seen in the past for this problem and related problems?

0 1 2 3 4 Name of therapist/s and location: _____

Are you presently in psychotherapy / counseling with anyone? Yes No If yes, Who? _____

Have you ever been diagnosed with a mental illness? Yes No

If yes, what was the diagnosis? _____

Have you been hospitalized for psychiatric problems? Yes No

If yes, how many times? ____ What is the name of the treatment facility and location? _____

When was the last time? _____

Please let me know who referred you or how you heard about me: _____

What are some initial things you'd like me to know about you? _____

_____

*PLEASE INDICATE WHO SHOULD BE CONTACTED IN CASE OF AN EMERGENCY:
(names and phone numbers)

_____

*completion of this section indicates permission to contact these people should an emergency (as determined by the therapist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.

PRIMARY INSURANCE

It is important that you call your insurance to verify the details of your "**out-patient behavioral health"** coverage. Sometimes, the coverage details are different than medical coverage. Since any charges not covered by your insurance are your responsibility, we strongly recommend that you call your insurance company prior to you first visit to ensure that the information you enter below is complete and accurate.

If you are not using insurance, please write "no insurance" below.

Patient's Name: _____ *Policy Holder's Name*: _____

*Policy Holder's Address & telephone:*_____

Patient's Relationship to Policy Holder: _____

Patient's Birth Date:_____ *Policy Holder's Birth Date*:_____

Insurance Company Name: _____
Employer: _____

Member ID #: _____ Group #: _____

How many visits are allowed per year?: _____ What is your Co-Pay / Co-insurance?:_____ _____

Is an Authorization needed? _____Obtained?:_____ Authorization Number: _____

Employee Assistance Company: _____ Telephone Number: _____

Number of Sessions Approved by EAP? _____ Authorization for EAP_____

IMPORTANT INFORMATION CONCERNING INSURANCE

If you have insurance, I will help you receive maximum benefits available through your insurance. However, I cannot guarantee coverage or payment. Submitting insurance claims is a courtesy that I extend to my clients - all charges are your responsibility from the date of service. You are responsible for your deductible and co-pays/co-insurance not covered by your insurance. These payments are due at the time of your visit. Communication is essential. If any of the above policies are unclear to you, please ask prior to the initial meeting. Your satisfaction is very important to me! If you feel that there are extenuating circumstances in your case, please immediately bring these to my attention. By signing below, you are authorizing the release of any necessary information to your insurance carrier or other agent preparing claims for payment of the office charges. This also authorizes payment of benefits to be paid directly to the counselor. Signing below also indicates that you understand that you are responsible for full financial costs related to your care should my insurance carrier decline payment for services rendered by Stacey O. Kitchens.

Client (or Responsible Party) Signature: _____ Date: _____

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INFORMED WRITTEN CONSENT FOR TREATMENT
POLICY STATEMENT and REGISTRATION FORMS

Thank you for selecting me as your counselor. The intent of this form is to inform you about the basic treatment relationship between counselor and client, to inform you of basic policies, to inform you about my professional background, and to help ensure that you understand our professional relationship. ***Please initial and date every page herein as the information is read, understood, and accepted*.**

About your therapist
I am an active member of the Licensed Professional Counselors Association of Georgia. I approach counseling from an integrative theoretical orientation. I draw heavily from Cognitive Behavioral therapy (CBT) in my approach to counseling, often deliberately and selectively combine elements of Reality therapy, Dialectical Behavior therapy (DBT), and Adlerian therapy, along with both directive and nondirective play therapy, as deemed appropriate based on the age, needs, and collaboratively determined treatment goals of each individual client.

PROFESSIONAL BACKGROUND:

- *I am licensed by the Georgia Board of Licensed Professional Counselors as a Licensed Professional Counselor (LPC #LPC006117)*
- *I hold a Master's Degree in Counseling Education, awarded by Georgia Southern University in May of 1997.*
- *I have over 25 years post-master's counseling experience with children, adolescents, and adults, and have an additional 2 years pre-master and undergraduate experience in career exploration and personal guidance with college students.*
- *I am currently serving children, adolescents and adults, in individual, family and group therapy, family therapy; stepfamily dynamics, trauma issues, and military adjustment issues.*

COUNSELING PHILOSOPHY, EXPECTATIONS OF CLIENTS:

I believe strongly in the capacity of people to help themselves and I see our counseling relationship as one in which you assist in setting your goals. I am privileged to travel with you as you work toward attaining your goals. I expect that you will be involved in the counseling process and that you understand that I will work ***with* you, not *for* you**. My approach to therapy is basically a holistic one: we will discuss your issues from many perspectives and examine the effects on your body, mind, work, spirit, relationships, and any other areas that may be meaningful to you. Your decision to choose to enter counseling is a voluntary one and you may terminate it at any time without penalty. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will provide you with names and numbers of therapists for you to contact, if you wish. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, we will work together to
achieve the best possible results for you. Please note that our first meeting will be a 45-minute meeting, as are all sessions. At the end of the initial session we will each decide if we want to enter a counseling relationship. If we both agree to begin a counseling relationship, you will sign, date, and keep a copy of this informed consent, and I will be considered your therapist until termination occurs or until I have not seen you in session for more than 4 (four) weeks from the date of our last session.

Initial_____ Date_____
Initial_____ Date_____

I will encourage you to work toward your personal best level of health. I believe that as people become more aware of and accepting of themselves, they are more capable of creating fulfillment and well-being in an emotional, spiritual, and physical sense. My counseling setting is a safe place in which you are welcome to explore experiences, thoughts, and feelings. I will work with you to help you set goals that are important and meaningful to you. I use an eclectic approach, yet my main theoretical orientation is that of Choice Theory. Using this, I will work toward helping you to recognize and understand choices in behaviors, thoughts, and attitudes, and help you consider and make choices that you believe will be helpful in reaching your goals. Other theoretical perspectives and techniques I use include Cognitive Behavioral Therapy, Rational Emotive Behavioral Therapy, Motivational Interviewing, and Stages of Change models.

During the course of our counseling relationship, I may render a diagnosis of your mental health condition. I will discuss this diagnosis with you, and it will then become a part of your confidential records. It is important for your progress in counseling that you are able to confide in me without reservation. A counseling relationship between a counselor and client is a professional relationship in which the counselor assists the client in exploring and resolving difficult life issues. While some clients may need only a few counseling sessions to accomplish their goals, others may require months or even years of counseling. If counseling is successful, you will, at some point, feel that you are able to face life's challenges in the future without my help.

You, as the client, are in complete control and may end our counseling relationship at any point. I will be supportive of that decision, and I encourage you to have a last session to summarize our work together and plan for your ongoing wellness and growth. My counseling services are limited to the scheduled sessions we have together. If, between sessions, you experience a worsening of symptoms and feel the need to see me sooner than scheduled, you can contact me to schedule an earlier appointment. In the event you think your mental health requires emergency attention or if you have an emotional crisis after business hours, you can contact emergency services by **calling 911** (in the case of immediate potential harm to self or others) and request mental health services.

You may leave me a voice mail message at any time; although I check my phones messages regularly and try to respond in a timely way, please be aware that I may not be available to call back until the next business day. Please do not email me. I cannot guarantee confidentiality through emails or other electronic communications, nor do I know who is on the other end of the computer. My general response to anyone who chooses to email may be, "please give me a call." Although you may share very personal things with me during our sessions, it is important for you to realize that in order for me to provide the most effective counseling services possible, we must have a professional, rather than a personal, relationship. Our contact will be limited to the paid sessions you have with me. I am unable to accept invitations to social gatherings, gifts, etc. outside our counseling sessions. If I happen to see you in public, for reasons of maintaining confidentiality I will not acknowledge you unless you acknowledge me first. I believe that you will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn about me as we work together during your counseling experience. However, it is important to remember that you are experiencing me only in my professional role.

Benefits and Risks of Counseling

The benefits of counseling have been shown by scientists in hundreds of well-researched studies. People who are depressed often find their mood lifting. Anxieties that prevent an individual from normal functioning can be mastered through techniques learned in therapy as well as the opportunity to master "run-away" thoughts that are causing dysfunction. In counseling often people need and have a chance to talk things out or for children play out what is bothering them until their feelings are very naturally resolved. Clients' skills in relationships and communication often greatly improve. The potential benefits of participating in counseling include relief from negative feelings, increased awareness of personal thoughts, behaviors, and attitudes, increased skills for coping with stressors and solving problems, increased satisfaction in relationships, increased clarity of personal goals and values, and increased capacity for enjoyment and for personal growth. The greatest benefit to counseling in my experience is learning how to develop and maintain a sense of balance in life which yields more lasting contentment, satisfaction and skills for coping with the inevitable challenges life presents. Please be aware that participation in counseling has the potential for both benefits and risks, and that these should be carefully weighed before choosing to participate in counseling.

Initial_____ Date_____
Initial_____ Date_____

There is the risk that through counseling clients may at times feel uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding way to balance. It is not uncommon (especially with children) for symptoms to worsen before improving. Clients may recall unpleasant memories. Anytime we are making changes for the better, the familiar existing way of being in the world and in relationships is stirred up and turned upside down to some degree and there is the risk that significant others in one's life may have their own objections or negative reactions to a client's positive changes. Changes made by you in your choices about behaviors as a result of participating in counseling may create disruption in relationships, including those with spouses or significant others, possibly even resulting in the end of the relationship(s). It is also important to recognize that problems or symptoms may temporarily worsen after starting counseling, and/or new problems may arise during counseling. And last, even with my best efforts, there is a risk that counseling may not have the positive results you would like. Overall, the benefits greatly outweigh the risks. It is impossible to guarantee any specific results regarding your counseling goals; however, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. It takes great courage to begin the process of counseling. If you have any questions about what to expect in your journey through counseling with me, I am more than happy to discuss this with you not only in our first session together but throughout the process.

Confidentiality

It is a client's legal right that our sessions and my records about you are kept private. I will tell no one what you or your child discloses or that you or your child/ren are receiving counseling services from me. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are exceptions as follows:

1. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person. This usually means telling others about the threat including police officials.
2. If I have reason to believe a child or any adult dependent has been or will be abused or neglected, I am legally required to report this to the proper authorities.
3. If you are or will be involved in court proceedings and my records are ordered by a judge.
4. If a guardian ad litem (GAL) is appointed in a custody case involving child clients I have seen for counseling services and she/he is ordered by the court to have access to mental health practitioners and records therein, I am required to provide that information as it is court ordered.
5. The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.
6. Occasionally I seek professional supervision or consultation with another licensed therapist as well as confidential peer consultation meetings in the area. I share information about my cases and clients for the purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity.
8. If you should choose to communicate with me via email regarding your appointment I cannot guarantee your confidentiality as sometimes an email remains on a server and may be accessible by others. I may or may not reply via email. Please do not email me.
9. In the case of my death or major medical incapacitation, all of my records will be accessed by Angie Eells, LCSW.
10. Any and all videotaping, recording, audio recording of the sessions, meetings, telephone conversations are prohibited and are not allowed in my office.

Initial_____ Date_____

Initial_____ Date_____

More on Confidentiality:
In working with children, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plans and progress, as well as recommendations.
In working with couples and families, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I will not be a "secret keeper" nor will I facilitate secret keeping.

Divorce and Custody Cases
*** I am not a custody evaluator and cannot make any recommendations regarding custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed/ or requested. ***

It is my policy not to testify in court in any custody or divorce cases. As a Licensed Professional Counselor, I cannot make any recommendations to the courts concerning custody, visitations, or offer any information to the courts. By agreeing to seek counseling services with me, you are also agreeing NOT to subpoena me or ask me to write a report and/or letter for any involvement with the court.
Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

1. If I am seeing a child whose parents are in the process of divorce or who are already divorced, I require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

2. I will be available to provide an interview with a guardian ad litem (GAL) assigned to investigate the best interest of any child I am counseling upon production of court order demonstrating the GAL's right to speak with me. Otherwise, the adult client or parents of child client will need to sign a release for me to speak with the GAL (see charges for these services below).

3. I will provide a summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

4. Family sessions will likely be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

5. **I ask all my clients to waive the right to subpoena me to court.** This policy is set in order so that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child(ren). It is my professional opinion that my appearance in court has the potential damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement, you are waiving the right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

Initial_____ Date_____
Initial_____ Date_____

6. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work for my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed. An explanation of the bill/fees associated are listed and explained below.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a sensitive and confidential nature, it is agreed that should you be involved in legal proceedings, neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

I understand these policies and hereby waive any and all rights to subpoena Stacey O. Kitchens, LPC, NCC and her clinical record on any current or future legal proceedings.

Printed Name_____ Signature_____ Date_____

Consent for Treatment & Release of Information for Legal and Judicial Purposes

The following document is intended to provide information about my services, fees and business polices in regards to legal cases or those cases that may require services above and beyond what is considered standard outpatient psychotherapy. These services include but are not limited to: letters for court, legal affidavit, assessments and reports, expert testimony and court appearances. Your signature will signify an agreement with these services and policies. I specialize in psychotherapy working with the needs of families, often with adolescents and children. I do not solicit nor encourage clientele seeking provider participation in potential legal cases such as divorce, child custody or criminal cases to retain my services. If a client anticipates or is specifically seeking these services, I will be happy to provide a referral to another provider more suited to these needs. However, I do understand there are extenuating circumstances in some cases and will on occasion agree to provide these services if otherwise unavoidable.

If it is agreed that I will provide requested services in relation to your legal case, let it be known that I will report and give my clinical opinion and diagnosis without prejudice and with the client's best interest in mind. This may not always coincide with what a parent or guardian feels is in their best interest especially in regard to child custody cases, but know that my job is to see to the needs and safety of the child and the child alone in these cases.

My fees for legal and reporting services are as follows:

- $250.00 **Retainer Fee** which is a non-refundable fee to be paid in advance required for all cases requiring or expected to require Expert Testimony / Court Appearance.
- $250.00 **Appearance Fee** This is in addition to the retainer fee, a Court appearance / Expert Testimony Fee will be charged for each scheduled court appearance.
- $250.00 **Affidavit/Deposition Fee** This fee will be charged for all written, verbal and video recorded affidavits and depositions. Travel expenses apply if therapist is required to meet with attorneys, representatives and/or officers of the court outside of the therapists office.
- $250.00 **Cancellation Fee** A fee will apply for all scheduled court appearances not canceled at least THREE DAYS in advance.
- $75.00 **Written Report Fee** Rate varies based on the complexity of report required, $75.00 minimum charge each report.
- $50.00 **Standard Letter Fee** A letter fee will apply for all letters requested by client or client representative(s) including but not limited to: treatment recommendations, diagnosis and treatment statements, school / work letters, etc.

- $50.00 – $75.00 **Paper Work Fee** Rate varies based on the complexity of forms to be completed by provider.
- $60.00 **Medical Records Fee** Rate varies based on volume of records to be copied. This rate includes standard postage. Shipping charges will be applied of overnight or next day delivery service is required. Payment is required in advance.
- $35.00 **Returned Check Fee** A $35.00 fee will be charged on all returned checks.

Travel expenses may apply and will be added to the final invoice depending on location of appearance. Travel expenses include but are not limited to: transportation, hotel and meals. Additional fees may apply depending on any additional requested services not covered in the above fee schedule. Our office will not bill Insurance for these services nor will we accept any payment of benefits from an insurer for these services. If a client would like to file a claim for reimbursement from an insurer, our office will be happy to provide a superbill / invoice outlining all charges and payments made. The client will be responsible for filing reimbursement claims with their insurer (If filing a claim, please be sure to mark claims appropriately with benefits being payable to you the client, not payable to the provider.) Retainer fees must be paid in full two weeks prior to or before trial date or I will be unable to appear in court. Subpoenas will be responded to but do not guarantee appearance in court without prepayment of retainer fee. All requested appearances must be scheduled with my office at least two weeks in advance. Letters, paper work and reports will take 1 – 2 weeks to complete and fees will be due upon delivery. Medical records requests will take 2-4 weeks to process and will shipped or be made available for pickup when payment is received in my office.

POLICIES CONCERNING ACCESS TO CONFIDENTIAL INFORMATION: Requests for access to information and records must be in writing and a signed release of information must be received or on file allowing for the release of information to a third party or designated representative. The practice will charge a reasonable cost-based fee for information retrieval, copying and mailing information as outlined above. Fees are due in advance, prior to release of information. However, in response to an information request, the provider may elect to provide information in a summary or report form rather than a complete copy of psychotherapy notes. This form serves as an advance written notice of requirements and fees to the individual requesting access. Additionally, the individual requesting the information is given the opportunity to agree in advance to information being presented in a summary form and fees being charged. Should summary and/or fee not be accepted, the request for information may be denied by the provider. The practice and its associates will act on a request for access to information within thirty (30) days when information is maintained on-site and within sixty (60) days when information is maintained off site. An extension of no more than thirty (30) days is allowed if the practice notifies the individual with a written statement of the reason for the delay and the date by which the practice will complete the action on the request. Further, a provider / practice has discretion to deny access to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under the rule and who may be subject to abuse or neglect.

I, the undersigned, AGREE to be financially responsible for all services requested and required in relation to my legal case and agree to all rates and fees as outlined above.

Signed:_____ Printed Name:_____
Date:_____

Session parameters:
Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time in order to meet scheduling obligations to other clients. The clock starts at the scheduled appointment time and the session will not be extended because of a late arrival. The fee for the session will not be prorated because of a late arrival.

Contacting You:
There may be occasions when my assistant may contact you for me or return your phone call for me. My assistant will only do this at my request and the message will concern things like changes in appointment times. She will never contact you regarding any confidential information.

Initial_____ Date_____
Initial_____ Date_____

Financial Responsibilities:

Cost: Your initial visit and diagnostic interview will be $95.00. Follow up visits will be billed at $95.00 for 45 minutes and $95.00 for 60 minutes. You may be seen on a self-pay basis or you may choose to utilize your insurance benefits if available. Please note, I do not have a "sliding scale" but there are discounts for self-pay or cash payments. I accept a number of insurances and strive to be on as many insurance panels as possible to better serve our community. However, I reserve the right to accept or not accept any form of insurance or plan at any time. If I am unable to accept your insurance for any reason, I will make every effort to inform you prior to being seen so that you may choose to seek treatment elsewhere or choose to be seen on a self-pay basis. If utilizing your insurance benefits, you are required to participate in obtaining a pre-authorization for therapeutic services paid through your insurance company. You will also be required to pay your co-payment at the time of each session including meeting deductible requirements. As well, a statement of benefits is not a guarantee of payment to this office. If for any reason the insurance provider does not pay benefits, it becomes the responsibility of the individual and/or family to make payment. Further, you may request a copy of your Super Bill for your visit in order to file a claim with your insurance company for reimbursement of payment, or at any time for personal financial use. Please see the Insurance section below for more information in regards to your insurance claims processing.

Scheduling and Cancellations: It is understood that if there is an emergency situation that prohibits a client from canceling within 24 hours, it can be can discussed with Stacey O. Kitchens directly and request a waiver of this policy but I understand that Stacey O. Kitchens is not bound to grant that waiver and may, by this contract, charge a $45.00 (forty-five dollar) fee for the first missed/cancelled appointment, the second missed/cancellation fee will be $55.00 and the third missed/cancellation fee will be 65.00.

Collections: Any accounts not paid within 90 days may be turned over to collections or taken to small claims court. We reserve the right to add a $25.00 late charge for delinquent accounts. Should collection be necessary, the responsible party agrees to pay all collection fees charged by the collection service and all legal fees of collection, with or without suit, including attorney fees and court costs. We will no longer be able to provide medical care once an account has gone to collections.

There is a **$35 fee for any returned checks.** That $35 fee is due at the time of your next session, along with the payment for that session. If I receive two (2) returned checks from you, I will require that you pay using cash or credit card only from that point on.

Individual Therapy: $95.00 for a 45 minute session
Couples / Family Therapy: $95.00 for a 45 minute session
Special Groups Therapy: $95.00 for a 45 minute session
PHONE CALLS (with you): longer than 10 minutes = $1.00 a minute after first 10 minutes
PAPERWORK TIME: $50.00 per Preparation of Summaries of Treatment at request of client, $50.00 per item/form completion requested, $50.00 flat fee for copies of a file; $50.00 flat administrative fee to prepare file for copying.

Please be aware that I charge for and expect payment for phone time (time after the first 10 minutes), for non-session time related to you, and for all paperwork time related to you. In order to keep my fees as low as possible, I charge for and expect payment for these services. Payment is due at the time of your session prior to the rendering of these services. Should it become necessary to raise my therapy fee, you will be given 2 months notice and the increase will not be more than $15 per session. Your fee will not be raised more than 1 time within a 12-month period which begins with your first session with me. Should you re-enter counseling with me after your case has been closed, you will be charged whatever fee is specified in the terms of the Informed Consent used at the time you begin counseling again, whether 12 months has elapsed or not. FULL PAYMENT (CHECK, CASH, credit card) IS DUE WHEN YOU ARRIVE FOR YOUR SESSION. There is a discount for cash /check OR MONEY ORDER payments.

Initial_____ Date_____

Initial_____ Date_____

Office Hours:
Monday-Friday (days vary weekly) 8:00-4:00 with limited evening and Saturday appointments. The hours listed excludes most holidays.

After Hour Support and Emergencies:
Counseling Services Stacey O. Kitchens, LPC is not an emergency services agency. I do not provide emergency services. You may call me during business hours on my mobile office number 404-217-8161 and leave me a voicemail including your phone number (even if you know that I have it) along with a brief message. I will call you back when I have finished all sessions and business with other clients or between sessions if possible and if not possible the same day that you have the message, as soon as I am able. I do not specialize in crisis intervention. Clients are assumed to be self-responsible, autonomous, functioning adults, or children in the care of functioning adults, who are not in need of day-to-day supervision. I cannot and do not assume responsibility for clients' daily functioning the way that institution can.

When I am away from the office for extended time, my outgoing voicemail message will reflect when I will be back. I also provide all clients, in advance, my away-from-office dates.

If you have a life-threatening emergency, you should call 911 or go to the hospital of your choice.

Only contact me in an emergency after you have already obtained emergency assistance from 911 or your choice of medical/mental health support

Below are some 24 hour Mental Health Resources (not to be substituted for calling 911 with emergency):

Ridgeview Institute at 770.242.4567
Peachford Hospital at 770.454.5589
Cobb Mental Health Crisis Line 770.422.0202
Fulton Mental Health Crisis Line 404.730.1600

Records
Please be aware that, pursuant to HIPAA, I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record if requested in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of $50 charged for the time it takes to confidentially copy and prepare the record for release. Your folder is kept for 7 years from last date seen. Your folder contains my copy of this informed consent, your client information form, and all materials that pertain to you, including your progress notes. This folder is confidential with the exceptions noted in this document. Your folder is protected by 3 locks. Your folder will be destroyed by shredding at the end of 7 years.

E-practice / Notice
All client information will be handled in a secure manner ensuring confidentiality as covered in our Notice of Privacy Policies given and made available to all clients. Our office contracts with a secure Electronic Records Management System (Therasoft). This system manages and stores all client and insurance information in a safe and secure manner in accordance with HIPAA laws and guidelines. All communication from clients concerning appointments are expected to be handled by phone and not by email in order to prevent

communication errors as per our policies. Any communication with a client via email by this office will be limited in order to ensure confidentiality and security.

Initial_____ Date_____
Initial_____Date_____

It is sometimes necessary for our office to transmit/exchange information electronically for the purposes of insurance verification, claims filing, referrals and forwarding of information and messages per client and/or at the therapist's request. Our office may use electronic devices and means of communication such as facsimile and email in order to transmit information. All systems are secure and client information is kept confidential according to HIPAA guidelines and laws. It is important to know there are benefits and risks to electronic transmittal and exchange of information. While quicker delivery and response times are beneficial there is some risk of information being misdirected. This risk is minimal, however procedures and privacy notices are in place to protect your information and confidentiality. With this, all electronic transmittal of information is done in a secure manner and on an as needed basis in accordance with privacy policies and HIPAA laws

Our Agreement to Enter into Counseling Services

I have read or had read to me all the information in this above paperwork pages 1 - 13, have initialed all pages indicating that I have read them and understand them, have had a chance to review and ask questions and have had all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling.

I understand the potential risks and benefits of counseling, and I understand that I may ask questions about my treatment and/or request a review of my treatment progress at any time. I agree that my request for services is voluntary and that I may refuse a specific treatment or discontinue treatment altogether at any time. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided. I understand my rights as described above. I agree to take financial responsibility for my sessions at the rate of $80, or as indicated by your insurance co-payment per 45-minute session.

I certify that I have read, and had explained to me where necessary, fully understand, and agree with the contents of this Professional Disclosure Statement and Consent to Treatment. My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). I affirm that prior to becoming a patient of Stacey O. Kitchens, LPC, NCC she gave me sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand her office policies and procedures. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment at any time. I also hereby acknowledge that I have received the HIPAA notice form mentioned herein.

> *I further authorize Stacey O. Kitchens, LPC, NCC to release/disclose, receive, or, exchange information as noted below verbally and in writing the following information in the event that communication is necessary between the therapist and SOS and/or NBCC: treatment plan, progress in treatment, compliance, attendance, diagnosis, and any additional findings during treatment that may be necessary in a ruling. This authorization becomes effective on the date it is signed and may be revoked in writing. I further understand that the information authorized by this release will be released to the authorized recipient only for the purpose noted above. I understand that I am entitled to a copy of this authorization.*

If you have any questions or concerns about the information contained in this disclosure statement, please ask me. Once you are certain you understand this entire Professional Disclosure Statement and Consent to Treatment, please sign and date both forms, and keep one copy for your records; the other copy will be a part of your records maintained in my office. Again, thank you for choosing me as a provider, and I look forward to working with you.

_____ _____
Signature of client or client's legal guardian if client is a minor Date

_____ _____
Stacey O. Kitchens, LPC, NCC Date

Counseling Services Stacey O. Kitchens, LLC
Stacey O. Kitchens, LPC, NCC
4139 Baker Street, Suite #16
Covington, GA 30014

PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.

This notice shall go into effect January 1, 2008 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: *treatment, payment, and health care operations.***
Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.
Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.
Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."
The ***use*** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. ***Disclosures*** refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate form the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *my* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes.

Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record." You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as "Business Associates." I do employ business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client's Rights and My Duties

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of non-authorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

I am the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Initial_____ Date_____
Initial_____ Date_____

NOTICE OF PRIVACY POLICIES

This Notice of Privacy describes how confidential information about you may be used or disclosed and how an individual may go about gaining access to confidential information and/or receiving a copy of their mental health records. Counseling Services, its clinicians and business associates are committed to treating and using protected mental health information about you responsibly. This Notice of Health Information Practices describes the personal information which will be collected from you and how this information may be used and disclosed. This notice also describes your rights as they relate to your protected mental health information. This Notice of Privacy policy is effective February 1, 2011 and applies to all protected mental health information as defined by federal regulations. Counseling Services Stacey O. Kitchens, LLC reserves the right to change practices, policies and procedures. Any changes and new provisions will be made effective for all protected mental health information we maintain. Should our information practices change a revised notice will be mailed to clients.

Understanding Mental Health Records & Rights

Understanding what is in your record and how your mental health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your mental health information, and make more informed decisions when authorizing disclosures to others.

Each time you contact Counseling Services Stacey O. Kitchens, LLC a record of your contact is made. Typically, this record contains your contact information, issue(s) to be addressed by the clinician or office staff, symptoms and follow up needed or required. ***This information becomes a part of your mental health/medical record and serves as a:***

- Basis for planning your care and treatment. • Means by which you or a third-party payer can verify information and/or services • Means of communication among professionals and staff members who provided.
- An audit tool for Counseling Services Stacey O. Kitchens, LLC to insure confidentiality and compliance.
- Legal document of information exchange.

Your mental health record is the physical property of Counseling Services Stacey O. Kitchens, LLC, but the information contained within it belongs to you. ***You have the right to:***

- Inspect and copy your mental health record as provided for 45 CFR 164.524.
- Request amendment to your mental health record as provided in 45 CFR 164.528.
- Request communications of your mental health information
- Request a restriction on certain uses and disclosures of your information as provided by 45CFR 164.522.
- Revoke your authorization to use or disclose mental health information

Practice & Provider Responsibilities

Counseling Services Stacey O. Kitchens, LLC will not use or disclose your mental health information without your authorization, except as described in this notice. We will also discontinue the use or disclosure of your mental health information after we have received a written revocation of the authorization according to the procedures included in the authorization. ***We are required to:***

- Maintain the privacy of your mental health information.
- Notify you if we are unable to agree to a requested restriction.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Accommodate reasonable requests you may have to communicate mental health information by alternative means.
- Abide by the terms of this notice.

Counseling Services, Stacey O. Kitchens LLC reserves the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied.

For More Information or to Report a Problem

If you have questions and would like additional information concerning our privacy and confidentiality policies and procedures, please contact me at: Counseling Services Stacey O. Kitchens, LLC 3113 Emory Street Covington, GA 30014

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Initial_____ Date_____
Initial_____ Date_____

Counseling Services
Stacey O. Kitchens, LLC

Release and Waiver of Liability, Assumption of Risk, and Indemnity Agreement

IN CONSIDERATION OF BEING PERMITTED TO PARTICIPATE IN ANY WAY IN COUNSELING SERVICES-STACEY O. KITCHENS, LLC, I AND/OR MY MINOR CHILD, OUR PERSONAL REPRESENTATIVES, ASSIGNS, HEIRS, AND NEXT OF KIN:

HEREBY ACCEPT AND ASSUME ALL SUCH RISKS, KNOWN AND UNKNOWN, AND ASSUME ALL RESPONSIBILITY FOR THE LOSSES, COSTS, AND/OR DAMAGES FOLLOWING SUCH INJURY, DISABILITY, PARALYSIS, OR DEATH, EVEN IF CAUSED, IN WHOLE OR IN PART, BY THE NEGLIGENCE OF THE"RELEASEES": Counseling Services-Stacey O. Kitchens, LLC

HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE COUNSELING SERVICES – STACEY O. KITCHENS, LLC HER RESPECTIVE ADMINISTRATORS, DIRECTORS, AGENTS, OFFICERS, OFFICIALS, VOLUNTEERS, AND EMPLOYEES, OTHER PARTICIPANTS, ANY SPONSORS, ADVERTISERS, AND IF APPLICABLE, OWNERS AND LESSORS OF PREMISES ON WHICH THE ACTIVITY TAKES PLACE, (EACH CONSIDERED ONE OF THE "RELEASEES" HEREIN) FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON MY ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE "RELEASEES" OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATIONS; AND I FURTHER AGREE THAT IF, DESPITE THIS RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT I AND/OR MY MINOR CHILD, OR ANYONE ON MY AND/OR MY MINOR CHILD'S BEHALF, MAKES A CLAIM AGAINST ANY OF THE RELEASES, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES FROM ANY LITIGATION EXPENSES, ATTORNEY FEES, LOSS, LIABILITY, DAMAGE, OR COST WHICH MAY INCUR AS THE RESULT OF SUCH CLAIM.

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

_____	_____	_____
Signature of Participant	Print Name	Date

_____	_____	_____
Signature of Participant	Print Name	Date

Counseling Services Stacey O. Kitchens, LLC
Stacey O. Kitchens, LPC, NCC
4139 Baker Street, Suite #16
Covington, GA 30014

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual home. Please complete only the top half of this form.

I wish to be contacted in the following manner (check all that apply):

Home Phone Number:_____

___OK to leave message with detailed information
___Leave message with name & call back number only
___Do not leave messages at home number

Written Communication

___OK to mail to my home address
___OK to mail to my work/office address

Work Phone Number:_____
___OK to leave message with detailed information
___Leave message with name & call back number only
___Do not call me at work

Cell Phone Number: _____
___OK to leave message w/detailed information
___Leave message name & call back number only
___Do not call me at this number.

_____ _____
Client/Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

Counseling Services Stacey O. Kitchens, LLC
Stacey O. Kitchens, LPC, NCC
4139 Baker Street, Suite #16
Covington, GA 30014

Fees for Services Agreement

Every time I schedule an appointment with Stacey O. Kitchens (Therapist), I understand that I am continuing my contract with Stacey O. Kitchens (Therapist) and expected to pay for the professional time and services rendered. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand Stacey O. Kitchens' professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. At this time the therapist and I have agreed that my fee for sessions will be **$_____**and I agree to pay this fee at the beginning of my session. I understand that Counseling Services Stacey O. Kitchens, LLC does not reimburse for canceled appointments that were paid for in advance.

I agree that if the cancellation is not an emergency, I will be charged a $45.00 (forty-five dollars) fee for the appointment, the second cancellation fee will be $55.00 (fifty-five dollars) and the third cancellation fee will be 65.00 (sixty-five dollars). I hereby authorize Counseling Services Stacey Kitchens, LLC to charge my Visa/ Master Card/ Discover (circle one) credit card.

Card Number_____ Expiration Date_____ CV Code _____ Zip Code _____

If I indeed fail to observe this cancellation policy as I understand, I am paying for preparation services rendered and time contracted for the scheduled appointment. I also understand if there is an emergency situation that prohibits me from canceling within 24 hours, I can discuss this with Stacey O. Kitchens (Therapist) directly *and request a waiver of this policy* but I understand that Stacey O. Kitchens (Therapist) is not bound to grant that waiver and may by this contract proceed with charging my credit card as agreed herein.

_____
Client (or parent/legal guardian of child client) Printed Name

_____ _____
Client (or parent/legal guardian of child) Signature Date

_____ _____
Stacey O. Kitchens, LPC, NCC Date

Counseling Services Stacey O. Kitchens, LLC

Stacey Kitchens, NCC, LPC
4139 Baker Street
Covington, GA 30014
(telephone) 404-217-8161 (fax) 678-559-0688

GOOD FAITH ESTIMATE FOR HEALTHCARE COSTS AND SERVICES

Patient Name: _____ Date of Birth: _____

Depending on our progress, I expect that my care of you will require continued (maximum) weekly therapy sessions continuing through the end of the year as follows:

Service Code	Service/Item	Diagnosis Code	Cost Each	Quantity	Total Cost
____90837/95	Individual Psychotherapy, 60 minutes	_____	**$95.00**	**52 sessions**	**$4,940.00**
____90847 /95	Family Psychotherapy	_____	**$95.00**	**52 session**	**$4,940.00**

Total Expected (maximum) Charges $ 4,940.00

All services will be provided by:
Counseling Services Stacey O. Kitchens, LLC
Stacey Kitchens, NCC, LPC NPI # 157865641 LPC # 006117
Services will be provided at:
4139 Baker Street Covington, GA 30014 (or via Telehealth)

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. If patient chooses to use insurance, this estimate does not include the amount that may be paid by the insurance carrier.

Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.
Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

_____ _____

Signature of person receiving care (or parent/guardian if person receiving care is under the age of 18). Date