COUNSELING SERVICES STACEY O. KITCHENS, LLC

NEW CLIENT REGISTRATION & DEMOGRAPHIC INFORMATION

Please complete all applicable sections. Use N/A when a question does not apply.

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

CLIENT INFORMATION

Legal Name	_____
Preferred Name	_____
Date of Birth	_____
Street Address	_____
City / State / ZIP	_____
Home Phone	_____
Cell Phone	_____
Email (if used)	_____

Sex: ☐ Male ☐ Female ☐ Prefer not to state

EMPLOYMENT / EDUCATION

Employment Status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Student (PT/FT)

Employer	_____
Occupation	_____
Highest Level of Education	_____

RELATIONSHIP / FAMILY

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

Partner/Spouse/Parent Name	_____
Date of Birth	_____

Children / Household Members

Name	DOB	Age	Lives With You?	Grade/School
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

I certify that the registration information I have provided is accurate to the best of my knowledge.

Signature: _____ Date: _____

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

COUNSELING SERVICES STACEY O. KITCHENS, LLC

EMERGENCY CONTACT & COMMUNICATION PREFERENCES

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

EMERGENCY CONTACT

Name	_____
Relationship	_____
Primary Phone	_____
Alternate Phone	_____

If you choose not to complete an emergency contact, the practice's existing policy states that 911 will be contacted in an emergency as determined by the therapist.

COMMUNICATION PREFERENCES

Home Phone: ☐ OK to leave detailed information ☐ Name/call-back number only ☐ Do not leave messages

Work Phone: ☐ OK to leave detailed information ☐ Name/call-back number only ☐ Do not call at work

Cell Phone: ☐ OK to leave detailed information ☐ Name/call-back number only ☐ Do not call this number

Written Communication: ☐ Home address ☐ Work/office address ☐ Other: _____

Preferred contact method: ☐ Phone ☐ Text (if permitted by office policy) ☐ Other: _____

EMAIL / ELECTRONIC COMMUNICATION

The existing practice materials state that appointment communication should be handled by phone and that confidentiality through email or other electronic communication cannot be guaranteed. The practice may use secure electronic systems for limited administrative, insurance, referral, or treatment-related purposes.

I have reviewed the communication preferences and electronic communication policy.

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

CLINICAL INTAKE & TREATMENT GOALS

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

REASON FOR SEEKING COUNSELING

What brings you to counseling at this time?

_____

_____

_____

What do you hope to accomplish through counseling?

_____

_____

_____

What are some initial things you would like your counselor to know about you?

_____

_____

REFERRAL

How did you hear about this practice?	_____
Who referred you?	_____

PREVIOUS COUNSELING / TREATMENT

How many therapists/counselors have you seen for this or related concerns? □ 0 □ 1 □ 2 □ 3 □ 4+

Previous therapist(s) / location	_____
Currently in counseling?	□ Yes □ No If yes, with whom? _____

MENTAL HEALTH HISTORY

Have you ever been diagnosed with a mental health condition? □ Yes □ No

If yes, diagnosis	_____
Psychiatric hospitalization?	□ Yes □ No
If yes: number / facility / location	_____
Most recent hospitalization	_____

I have completed this clinical intake information to the best of my knowledge

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

COUNSELING SERVICES STACEY O. KITCHENS, LLC

MEDICAL HISTORY & PRIMARY CARE

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

MEDICAL HISTORY

Please list current medical conditions, significant medical history, or other health information relevant to counseling.

_____

_____

_____

CURRENT MEDICATIONS

Please list prescription medications, over-the-counter medications, and other relevant medications.

_____

_____

_____

PRIMARY CARE PROVIDER

Provider Name	_____
Practice / Location	_____
Phone	_____

May the practice contact your PCP when clinically or administratively appropriate? ☐ Yes ☐ No

Note: A separate Release/Authorization form may be required before information is disclosed to an outside provider.

CHILD / ADOLESCENT CLIENTS

For a minor client, please identify the legal parent/guardian responsible for consent and provide custody/legal documentation when applicable.

Legal Parent/Guardian	_____
Relationship to Client	_____
Phone	_____
Legal decision-making authority	☐ Sole ☐ Joint ☐ Other: _____

I understand that legal/custody documentation may be required for treatment of a minor.

COUNSELING SERVICES STACEY O. KITCHENS, LLC

INSURANCE & FINANCIAL INFORMATION

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

INSURANCE

If you are not using insurance, write "NO INSURANCE." The existing practice materials recommend that clients verify outpatient behavioral-health benefits directly with their insurer.

Patient Name	_____
Policy Holder Name	_____
Policy Holder Address/Phone	_____
Patient Relationship to Policy Holder	_____
Patient DOB	_____
Policy Holder DOB	_____
Insurance Company	_____
Employer	_____
Member ID	_____
Group Number	_____
Visits Allowed / Year	_____
Copay / Coinsurance	_____
Authorization Required?	☐ Yes ☐ No
Authorization Number	_____

EAP (IF APPLICABLE)

EAP Company	_____
Telephone	_____
Approved Sessions	_____
Authorization Number	_____

FINANCIAL RESPONSIBILITY

Insurance billing is provided as a courtesy when applicable. The existing office policy states that insurance coverage or payment cannot be guaranteed and that the client/responsible party remains financially responsible for charges not paid by insurance.

I understand that I am responsible for verifying my insurance benefits and for charges not paid by my insurance carrier.

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ABOUT YOUR COUNSELOR

With more than 20 years of professional master-level psychotherapist experience, a Specialist Degree (Ed.S.) in Supervision and Leadership, and a deep background in anger management and crisis resolution, I provide high-caliber, objective-driven counseling tailored to your unique challenges. Whether you are navigating interpersonal conflict, managing high-stress transitions, or looking to regain control of emotional triggers, my practice offers a structured, solution-focused environment designed to transform pressure into personal growth.

My path as a therapist is grounded in unique, real-world leadership and profound cross-cultural experience. Having served for 17 years as a High School Lead Counselor, I have spent nearly two decades directing crisis response teams and guiding individuals through acute life disruptions with a calm, steady hand. This regional expertise is enriched by a global perspective shaped during my time in the Peace Corps teaching English in Ukraine, which instilled in me a deep capacity for psychological first aid, rapid rapport-building, and adaptability. I integrate these rich backgrounds into every session, offering you an empathetic yet highly practical framework for healing and self-mastery.

As a National Certified Counselor (NCC) holding advanced certifications in Critical Incident Stress Management (CCISM), I am proud to offer both face-to-face and seamless, secure telehealth sessions to individuals across Georgia and South Carolina.

Professional Credentials

- **Education:** Specialist in Education (Ed.S.) in Supervision and Leadership
- **Licensure:** Licensed Professional Counselor (Georgia & South Carolina)
- **Board Certification:** NBCC Board Certified National Certified Counselor (NCC)
- **Crisis Credentials:** Certified Critical Incident Stress Management (CCISM)
- **Specialties:** Certified Anger Management Specialist, EAP Preferred Provider
- **Hypnotherapist :** In training program to be complete in October 2026 (NBCCH)

COUNSELING APPROACH

The existing materials describe an integrative/eclectic approach drawing from Choice Theory, Cognitive Behavioral Therapy (CBT), Rational Emotive Behavioral Therapy, Motivational Interviewing, Stages of Change, Reality Therapy, DBT, Adlerian approaches, and directive/nondirective play therapy as appropriate to the client and treatment goals.

EXPECTATIONS & NATURE OF COUNSELING

Counseling is a collaborative process in which the client participates in establishing goals.
The counseling relationship is professional and is intended to focus on the client's concerns and treatment goals.
The client may ask questions about treatment and may request a review of treatment progress.
Participation in counseling is voluntary, and a client may choose to discontinue treatment.
No specific result or outcome of counseling can be guaranteed.
The counselor may provide referrals when another provider or service is more appropriate.
The existing materials identify 45-minute sessions as the standard session length; current fees should be confirmed on the Financial Policy/Agreement.

I have read and understand the nature of counseling and the professional relationship described above.

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

BENEFITS, RISKS & CONFIDENTIALITY

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

BENEFITS AND RISKS OF COUNSELING

The existing informed-consent materials describe potential benefits including increased awareness, improved coping and problem-solving skills, improved communication and relationships, greater clarity about goals and values, and personal growth. Counseling may also involve discomfort, sadness, anxiety, frustration, difficult memories, changes in relationships, temporary worsening of symptoms, or the possibility that counseling may not produce the desired results.

CONFIDENTIALITY

The existing materials state that counseling sessions and records are intended to remain private, subject to legal and ethical exceptions.

The existing practice materials identify exceptions including:

- A serious threat of harm to self or another person.
- Suspected abuse or neglect when reporting is legally required.
- Court proceedings or court orders requiring disclosure.
- Certain court-ordered guardian ad litem access in custody matters.
- Other disclosures required or permitted by applicable law.
- Professional supervision or consultation conducted without revealing identifying information, as described in the practice materials.

RECORDING

The existing office policy states that videotaping, audio recording, or recording of sessions, meetings, or telephone conversations is not permitted in the office.

PROFESSIONAL BOUNDARIES

The existing materials describe the counseling relationship as professional and state that social invitations and gifts outside the counseling relationship are not accepted. Public encounters are handled in a manner intended to protect confidentiality.

I have read and understand the benefits, risks, confidentiality provisions, and professional-boundary expectations.

OFFICE POLICIES & PROCEDURES

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

SESSION PARAMETERS

Sessions are scheduled for a specific start and end time. The existing policy states that if a client arrives late, the session will still end at the scheduled time and the fee will not be prorated because of the late arrival.

CONTACTING THE OFFICE

The existing materials state that clients may leave a voicemail and that calls will be returned as soon as reasonably possible. The practice is not an emergency-services agency.

SCHEDULING / CANCELLATIONS

The current materials state a 24-hour cancellation expectation and list graduated missed/cancellation fees of $45 for the first occurrence, $55 for the second, and $65 for the third. The materials also state that an emergency may be discussed with the therapist and a waiver may be requested, but a waiver is not guaranteed.

CURRENT FEES

The source materials contain inconsistent fee references ($80 in one consent section and $95 in multiple financial sections). For the ready-to-use packet, the session fee below is intentionally left as a fill-in field until you confirm the current fee.

Initial / Diagnostic Session	$_____
45-Minute Individual Session	$_____
60-Minute Session (if offered)	$_____
Couples / Family Session	$_____
Group / Other	$_____

NON-SESSION SERVICES

The source materials identify fees for phone time, paperwork, summaries, copies, records, letters, reports, and legal/court services. These should be confirmed in the separate Fee Schedule before use.

I have reviewed the office scheduling, cancellation, session-time, and fee provisions.

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

COUNSELING SERVICES STACEY O. KITCHENS, LLC

FINANCIAL RESPONSIBILITY & PAYMENT AGREEMENT

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

PAYMENT EXPECTATIONS

The client/responsible party agrees to pay the practice for services rendered. Insurance coverage is not a guarantee of payment. The client/responsible party is responsible for deductibles, copayments, coinsurance, denied claims, and other charges not paid by the insurer, as applicable.

COLLECTIONS / RETURNED PAYMENTS

The existing materials state that unpaid accounts may be referred to collections or small claims court and that a returned-check fee of $35 may apply. The source materials also state that a $25 late charge may be added to delinquent accounts. These policies should be confirmed before final implementation.

PAPERWORK / RECORDS / PHONE SERVICES

The source materials list fees for certain non-session services, including phone time over 10 minutes, preparation of treatment summaries, form completion, file copies, and administrative preparation of records. Current fees should be entered on the practice's Fee Schedule.

Phone time after 10 minutes	$_____ / minute
Treatment summary	$_____
Form completion	$_____
Record copy / preparation	$_____
Other administrative service	$_____

COUNSELING SERVICES AGREEMENT & CANCELLATION POLICY

By scheduling an appointment with Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM (Counseling Services Stacey O. Kitchens, LLC), I agree to the following financial and operational policies:

1. Professional Fees & Services
   • Fees cover both face-to-face session time and essential clinical preparation, case reviews, note-keeping, and confidential professional consultations.
   • Session Fee Schedule: (Payable at the beginning of each session).
   • Fees for canceled appointments are strictly non-refundable.
2. Cancellation & No-Show Policy
   Non-emergency cancellations made within 24 hours of the scheduled appointment time are subject to the following progressive fee structure:
   • First Cancellation: $45.00
   • Second Cancellation: $55.00

In true emergency situations, a waiver may be requested directly from the therapist. However, granting a waiver remains entirely at the therapist's discretion. If a waiver is denied, the scheduled fee applies.

Payment Authorization

I hereby authorize Counseling Services Stacey O. Kitchens, LLC to charge my credit card for any applicable session or cancellation fees.

Card Number: _____ Exp Date: _____ CV Code: _____
Zip: _____

By initializing below, I acknowledge that I have read, understood, and agree to be bound by these financial terms.

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

LEGAL, DIVORCE & CUSTODY POLICY

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

GENERAL POLICY

The existing practice materials state that the practice does not solicit clients for the purpose of participating in divorce, custody, criminal, or other legal proceedings and may refer clients to another provider when specialized forensic or court services are more appropriate.

CHILDREN IN DIVORCE / CUSTODY MATTERS

A current court order and/or parenting agreement may be required before treatment of a child when parents are divorced or involved in custody proceedings.
The practice may require contact with the parent/legal custodian who has authority to make medical decisions and may seek written consent from the appropriate legal custodian(s).
When a guardian ad litem is involved, the practice will follow applicable court orders and releases.
The existing policy states that treatment-plan information, progress summaries, and parent recommendations may be provided to parents who share legal custody, consistent with applicable law and court orders.

The practice does not serve as a custody evaluator under the existing policy.

COURT INVOLVEMENT

The existing materials state a policy against subpoenaing the therapist or therapy records and describe a litigation limitation. Because subpoena waivers, court testimony, records, custody matters, and fee provisions can have significant legal consequences, this section should receive attorney review before the packet is adopted.

I have read the legal/custody policy and understand that additional documentation may be required before treatment.

Counseling Services Stacey O. Kitchens, LLC • Client Initials: _____ Date: _____

LEGAL / COURT-RELATED SERVICES & FEES

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

SERVICES THAT MAY BE SUBJECT TO SPECIAL FEES

- Court appearances / expert testimony
- Affidavits and depositions
- Written reports
- Letters
- Forms and paperwork
- Medical/clinical record requests
- Attorney, guardian ad litem, or court-related consultation
- Travel associated with legal services
-

CURRENT SOURCE FEE SCHEDULE

The uploaded source lists the following fees. These are reproduced here for review and should be confirmed before the packet is put into active use:

Retainer Fee	$250.00
Court Appearance / Expert Testimony	$250.00
Affidavit / Deposition	$250.00
Court Appearance Cancellation	$250.00
Written Report	$75.00 minimum
Standard Letter	$50.00
Paperwork	$50.00–$75.00
Medical Records	$60.00
Returned Check	$35.00

The source also states that travel expenses may apply; legal services are not billed to insurance; requested appearances require advance scheduling; and retainer/payment requirements apply before court appearances.

CLIENT AGREEMENT

I understand that legal/court-related services are separate from ordinary outpatient counseling and that I am financially responsible for authorized services and applicable fees.

COUNSELING SERVICES STACEY O. KITCHENS, LLC

NOTICE OF PRIVACY PRACTICES — CLIENT ACKNOWLEDGMENT

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

IMPORTANT

The uploaded practice materials contain a detailed HIPAA/Privacy Notice. The existing notice describes protected health information (PHI), treatment/payment/healthcare operations, permitted uses and disclosures, client rights, business associates, records access, complaints, and privacy responsibilities. The current source notice contains effective dates from 2008 and 2011 and includes an older address in one section. Those items should be updated and legally reviewed before this notice is issued as the practice's official Notice of Privacy Practices.

CLIENT RIGHTS DESCRIBED IN THE EXISTING MATERIALS

- Request restrictions on certain uses and disclosures.
- Request confidential communications by alternative means or locations.
- Inspect and receive copies of qualifying records.
- Request amendment of information.
- Request an accounting of certain disclosures.
- Receive a paper copy of the notice.
- Revoke an authorization to the extent permitted by law.

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT

1. **Assumption of Risk**
   The undersigned ("Participant") knowingly and voluntarily assumes all risks, both known and unknown, associated with participating in counseling services provided by Counseling Services Stacey O. Kitchens, LLC ("Releasees"). Participant assumes full responsibility for any resulting financial loss, property damage, personal injury, disability, paralysis, or death, even if caused in whole or in part by the negligence of the Releasees.
2. **Release, Discharge, and Covenant Not to Sue**
   Participant hereby unconditionally releases, discharges, and covenants not to sue the Releasees, including its administrators, directors, agents, officers, volunteers, employees, sponsors, and premises owners, from any and all liability, claims, demands, or damages arising out of or related to the activity, including claims stemming from negligent rescue operations.
3. **Indemnification**
   If the Participant, their minor child, or anyone acting on their behalf asserts a claim against the Releasees despite this agreement, the Participant agrees to indemnify, defend, and hold harmless the Releasees against all litigation expenses, attorney fees, losses, liabilities, damages, or costs incurred as a result of such claim.
4. **Severability and Execution**
   This document constitutes a complete and unconditional release of all liability to the greatest extent permitted by law. If any provision of this agreement is deemed invalid or unenforceable by a court of competent jurisdiction, the remaining terms shall continue in full force and effect.
5.

CLIENT ACKNOWLEDGMENT

I acknowledge that I have been provided with the practice's Notice of Privacy Practices and understand that I may ask questions about my privacy rights and the practice's privacy procedures.

Client Signature _____ Date

_____

COUNSELING SERVICES STACEY O. KITCHENS, LLC

GOOD FAITH ESTIMATE — HEALTHCARE COSTS & SERVICES

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

This form is ONLY for self-pay clients

PATIENT INFORMATION

Patient Name	_____
Date of Birth	_____
Estimate Date	_____
Estimate Valid Through	_____

ESTIMATED SERVICES

Service Code	Service / Item	Diagnosis Code	Cost Each	Quantity	Estimated Total
_____	_____	_____	$_____	____	$_____
_____	_____	_____	$_____	____	$_____
_____	_____	_____	$_____	____	$_____
_____	_____	_____	$_____	____	$_____

Estimated Total: $_____

Provider: Counseling Services Stacey O. Kitchens, LLC | Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM
Service location: 4139 Baker Street, Suite #16, Covington, GA 30014 (or Telehealth, when applicable).

The uploaded source contains a Good Faith Estimate template and states that the estimate is based on information known when created and may not include unknown or unexpected costs. The official current federal notice/dispute language should be confirmed before this template is used.

COUNSELING SERVICES STACEY O. KITCHENS, LLC

FINAL CLIENT ACKNOWLEDGMENT & CONSENT

Stacey O'Neil-Kitchens, Ed.S., LPC, NCC, CCISM | 4139 Baker Street, Suite #16, Covington, GA 30014

PLEASE REVIEW BEFORE SIGNING

By signing below, I acknowledge that I have received and had an opportunity to review the applicable registration, informed-consent, office-policy, financial, privacy, and authorization materials provided by Counseling Services Stacey O. Kitchens, LLC.

- I have had an opportunity to ask questions and have had my questions answered to my satisfaction.
- I understand that counseling is voluntary and that I may ask questions about my treatment.
- I understand the potential benefits and risks of counseling.
- I understand the practice's confidentiality provisions and exceptions.
- I understand that insurance coverage is not a guarantee of payment and that I am responsible for applicable charges.
- I understand that separate written authorization may be required before information is released to an outside person or organization.
- If I am signing for a minor, I represent that I have the legal authority to consent to treatment or have provided the documentation requested by the practice.
- I understand that the practice is not an emergency-services agency and that life-threatening emergencies require emergency assistance.

Documents received / completed:

☐ Registration & Demographics
☐ Clinical Intake
☐ Medical / PCP Information
☐ Insurance & Financial Information
☐ Informed Consent
☐ Office Policies
☐ Notice of Privacy Practices
☐ Communication Preferences
☐ Release of Information (if applicable)
☐ Legal/Custody Policy (if applicable)
☐ Good Faith Estimate

CLIENT / RESPONSIBLE PARTY

Printed Name	_____
Signature	_____
Relationship to Client (if applicable)	_____
Date	_____