

# SJ | STOKAN JAGGERS &A | & ASSOCIATES

23501 Cinco Ranch Blvd., Ste. G270  
Katy, Texas 77494

## Client-Therapist Agreement Dr. Karen Jagers

**Practitioner:** \_\_\_\_\_

Welcome to Stokan Jagers & Associates. This agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment and health care operations. HIPAA requires that Stokan Jagers & Associates share with you a Notice of Privacy Practices for use and disclosure of PHI for treatment and health care operations. The Notice, which accompanies this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that Stokan Jagers & Associates has provided you with this information. Although these documents are long and sometimes complex, it is important that you read them carefully. We can discuss any questions you have about the procedures. When you sign that you have received this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on this agreement.

### SERVICES

Psychotherapy is not an exact science; it can have both benefits and risks. In order for it to be most helpful to you, it will require a very active effort on your part. There are no guarantees regarding outcome. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a devise a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me and make your own decisions about whether this is the course you wish to follow. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. For therapy to be most effective, you will need to put forth active effort both during sessions and in-between them as well. Throughout our work together I will continue to elicit your views and feedback about your treatment and progress. If you ever have questions about any aspect of your treatment, I encourage you to bring them to me. The more involved, honest, and open you are throughout the therapy process, the more effective it will be for you.

## BENEFITS AND RISKS

Therapy has both benefits and risks. While a majority of individuals who undertake therapy benefit from the process, there are no guarantees. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Success may vary depending on the particular problems being addressed. Since therapy often requires discussing unpleasant aspects of your life, risks sometimes include experiencing uncomfortable feelings such as unhappiness, anger, guilt, or frustration for example. These are a natural part of the therapy process and often provide the basis of change.

## CONFIDENTIALITY

The law protects the privacy of communications between a client and therapist. In most situations, I can release information about your treatment to others only if you sign a written authorization form. There are a few situations requiring only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During consultation, I make every effort to avoid revealing the identity of my client. The other professionals are legally bound to keep the information confidential.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can provide protection. Texas law provides that a mental health professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to himself/herself or others.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychotherapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization or a court order. If you are involved in, or are contemplating litigation, you should consult your attorney to determine if a court would be likely to order me to disclose information.
- If a government agency is requesting information for health oversight activities, I may be required to provide it to them.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency. Once a report is filed, I may be required to provide additional information.

- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon himself/herself, I may be required to take protective action by disclosing information to medical or law enforcement personnel.

If such a situation arises, I will make every effort to discuss it with you before taking action, and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

## MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents or guardian the right to examine your treatment records. I generally provide only general information to parents about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them this information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

## APPOINTMENTS

A scheduled appointment means that a 45-minute session is reserved only for you. Typically, appointments are scheduled weekly, but this can vary. If an appointment is missed or canceled with less than 24 hours notice, you will generally be billed directly according to the scheduled fee. An exception to this policy may be made if we agree that there were circumstances beyond your control.

## BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested.

## PROFESSIONAL FEES

My fees are **\$275.00** for the initial intake session and **\$210.00** for a 45-minute psychotherapy session. For other professional services you may need outside of our scheduled sessions, I will bill you on a prorated basis. These services may include telephone conversations lasting longer than fifteen minutes, extensive coordination of care, consulting with other professionals with your permission, report writing, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. In the unusual circumstance that you are involved in a legal proceeding that requires my participation, I may charge a higher fee for my professional time due to the complexity and difficulty of legal involvement.

## CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. I do not answer the telephone when I am with a client. I will make every effort to return your call on the same day you place it. This may not always include weekends or holidays. If you have an emergency that cannot reasonably wait until the end of the business day, you are urged to call 911 or contact the nearest emergency room and ask for the psychiatrist on call.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Signature: \_\_\_\_\_

Client's Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

If signing for a minor, Guardian's Signature: \_\_\_\_\_

Minor's Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CREDIT CARD AUTHORIZATION FORM

We accept HSA/FSA, Visa, Master Card, American Express, and Discover Cards.  
**Payment is rendered at time of visit.**

We ask that our clients complete a credit card authorization form which is included in this packet of new client forms and documents. This form is kept secure on file here in our office and is only accessible by management staff.

This form authorizes payments to Stokan Jagers & Associates as a provider of services for:

Patient's Name: \_\_\_\_\_

Credit Card Type:    VISA        MASTER CARD        DISCOVER        AMEX

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Security Code (CVV): \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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**For Office Staff ONLY:**

\_\_\_\_\_ In Person    \_\_\_\_\_ By Phone    \_\_\_\_\_ At Window    / Taken by: \_\_\_\_\_

## ADULT INTAKE FORM

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Please list any numbers where you do not want to be contacted?

\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Marital Status:** Married \_\_\_ Divorced \_\_\_ Single \_\_\_ Widowed \_\_\_ Engaged \_\_\_

How long have you been married, divorced, or widowed? \_\_\_\_\_

Number of previous marriages: \_\_\_\_\_ For your spouse: \_\_\_\_\_

If married, spouse's name: \_\_\_\_\_ Age: \_\_\_\_\_

Is your spouse supportive of you seeking counseling? Yes \_\_\_ No \_\_\_ Unsure \_\_\_ Unaware \_\_\_

Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Length of time at current job: \_\_\_\_\_ Highest Educational Degree: \_\_\_\_\_

Please list names and ages of your children if you have them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who else lives with you? \_\_\_\_\_

If you have had any previous counseling, psychiatric treatment, or residential/in-patient care, please list the names of the therapists and/or program and complete below.

Therapist's Name or Program	Major Issue	Dates

Please describe the most positive experience you have had in a counseling situation.

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Please describe the most negative experience you have had in a counseling situation.

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Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? If yes, please describe.

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Has anyone in your family ever attempted or committed suicide? If yes, please state who and when:

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Please circle any of the following symptoms that you are currently or have recently experienced.

ANXIETY	PANIC	DEPRESSION
LOSS OF APPETITE	OVEREATING	TROUBLE SLEEPING
FEELING WORTHLESS	RECENT DEATH	GRIEF
FATIGUE	PHYSICAL ABUSE	EMOTIONAL ABUSE
POOR CONCENTRATION	SEXUAL ABUSE	VERBAL ABUSE
GENDER IDENTITY ISSUES	ANGER	AGGRESSIVE BEHAVIOR
BAD DREAMS	UNWANTED MEMORIES	COMPULSIVE BEHAVIORS
SEEING THINGS OTHERS DON'T	HEARING VOICES	RACING THOUGHTS
SUBSTANCE ABUSE	PREGNANCY	ABORTION
LEGAL MATTERS	WORK STRESS	CAREER CHOICES
SPIRITUAL PROBLEMS	CHRONIC PAIN	LONELINESS
FEARS	SHYNESS	LOW SELF ESTEEM
LOSS OF CONTROL	IMPULSIVE BEHAVIORS	CONTROLLING
CONTROLLED BY OTHERS	OBSESSIVE THOUGHTS	FINANCIAL PROBLEMS
INDECISIVENESS	PARENTING PROBLEMS	OTHER

Are you currently experiencing any suicidal thoughts? Yes \_\_\_\_ No \_\_\_\_

Have you ever experienced suicidal thoughts in the past? Yes \_\_\_\_ No \_\_\_\_

Have you attempted suicide in the past? Yes \_\_\_\_ No \_\_\_\_

Are you currently experiencing any violent or homicidal thoughts? Yes \_\_\_\_ No \_\_\_\_

**SUBSTANCE USE HISTORY**

Have you ever experienced a problem with alcohol, drugs, or prescription medications?

Yes \_\_\_\_ No \_\_\_\_ If yes, please explain:

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**FAMILY BACKGROUND**

Who else lives with you?

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Check the statement(s) below that describe the type of family you grew up in:

- overly close family                       no “breathing room”                       no privacy
- boundaries not respected                       comfortably close family                       loving
- shared many positive experiences                       supportive                       distant
- not much time spent together                       not a lot of support                       violence
- angry, lots of fighting/hostility                       verbal abuse and conflicts                       frightening
- scared to make mistakes
- other descriptors:

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**HEALTH/MEDICAL INFORMATION**

How is your current physical health? (please check)

- Poor                       Fair                       Satisfactory                       Good                       Very good

Please list any significant medical problems/conditions, and indicate if you are receiving treatment for them:

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Do any of these problems affect your everyday life? Yes \_\_\_\_ No \_\_\_\_ If yes, how?

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Have you ever had a serious head injury? Yes \_\_\_\_ No \_\_\_\_ If so, please describe:

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List all medications that you currently use:

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Please list any “alternative” therapies/treatments you are currently using and the reason for each:

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**INTERESTS AND ACTIVITIES**

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are currently involved in:

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Please describe your personal strengths and characteristics:

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Other information you feel is important and wasn't asked:

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What are you hoping to gain from this counseling experience?

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How will you know when you have achieved this goal? What will it (you) look like?

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\_\_\_\_\_  
**Client's Signature**

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**Date**