SJ&A | STOKAN JAGGERS & ASSOCIATES

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

Client-Therapist Agreement

Practitioner: _____

Welcome to Stokan Jaggers & 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 Jaggers & 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 Jaggers & 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 $225.00 for the initial intake session and $175.00 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 Jaggers & 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: _____

DR. JAGGERS - COUPLES INTAKE FORM

Please type all your answer to the following questions to the best of your ability and then print the form one-sided.

IDENTIFYING INFORMATION

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____Cell phone: _____

Is it OK to contact you at home? ☐Yes ☐No OK to

leave a message? ☐Yes ☐No

Special calling instructions ☐Yes ☐No _____

_____

OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply: ☐ employed ☐retired
☐ disabled ☐student
☐ homemaker ☐unemployed

If/When employed, what type of work do you do? _____

_____

Are you currently having difficulties on the job? ☐Yes ☐No

If yes, please explain: _____

HEALTH/MEDICAL INFORMATION

How is your current physical health? _____

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

_____

Do any of these problems affect your everyday life? ☐ Yes ☐ No

If yes, how? _____

Have you every had a serious head injury? ☐ Yes ☐ No

If so, please describe: _____

List all medications that you currently use: _____

_____

_____

_____

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

_____

_____

_____

Please check any symptoms you are currently or have recently experienced:

☐ Depression
☐ Racing Thoughts
☐ Panic Attacks
☐ Sleep Disturbances
☐ Unexplained losses or time
☐ Poor Concentration
☐ Eating Disorder
☐ Repetitive Thoughts (Obsessions)
☐ Loneliness
☐ Stress
☐ Anger
☐ Rapid Speech
☐ Feeling Worthless
☐ Indecisiveness
☐ Intrusive Memories
☐ Vocal or Motor Tics
☐ Guilt
☐ Aggression
☐ Extreme Mood Swings
☐ Anxiety
☐ Phobias
☐ Hallucinations
☐ Unexplained Memory Lapses
☐ Frequent Body Complaints
☐ Body Image Problems
☐ Repetitive Behaviors
☐ Low-Self Esteem
☐ Impulsive Behaviors
☐ Fears
☐ Sadness
☐ Unmotivated
☐ Grief
☐ Spiritual Problems
☐ Startled Easily
☐ Fatigue
☐ Other: _____

SUBSTANCE USE HISTORY

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

☐ Yes ☐No If yes, please explain _____

_____

INTERESTS AND ACTIVITIES

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

_____

_____

_____

Please describe your personal strengths and characteristics:_____

_____

_____

_____

RELATIONSHIP QUESTIONS

Name of Spouse: _____

Marital/Relationship Status (select one):

☐ Married/committed
☐ Living Together
☐ Separated
☐ Living Apart
☐ Divorced
☐ Dating

Length of time in current relationship: _____

Is monogamy an expectation in your relationship? ☐Yes ☐No Children

(Type - biological, adopted, foster, step):

Name	Gender	Age	Type	Custody

Please check any of the reasons listed below that resulted in your request for therapy.
(If appropriate, specify self or partner)

☐ Depression or Anxiety
☐ Alcohol/Drug Abuse
☐ Marital Problems
☐ Communication Difficulties
☐ Extramarital Affair/Relationship
☐ Improve Sexual Relations
☐ Child/Parent Conflict
☐ Divorce Counseling
☐ Sexual Orientation Questions
☐ Suicidal Thoughts
☐ Homicidal Thoughts
☐ Difficulty with Loss or Death
☐ Relationship Enhancement
☐ Abuse (Physical/Mental)
☐ Medical/Physical Problem
☐ Pre-Marital Counseling
☐ Other _____

What is the primary issue that you are dealing with in your relationship? _____

_____

_____

How long have you had this issue? _____

_____

Have you had similar issues in past relationships? _____

_____

Why are you seeking help NOW? _____

_____

Have you received couple's therapy in the past? ☐Yes ☐No

If yes, when and with whom? _____

_____

What was the outcome? _____

_____

What are your greatest strengths as a couple? _____

_____

_____

What would you like to see happen as a result of therapy? _____

_____

_____

_____

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

- ☐ Overly close family
- ☐ Boundaries not respected
- ☐ Many positive experiences
- ☐ Not much time spent together
- ☐ Angry, lots of fighting/hostility
- ☐ Frightening
- ☐ no "breathing room"
- ☐ comfortably close family
- ☐ supportive
- ☐ not a lot of support
- ☐ verbal abuse and conflicts
- ☐ scared to make mistakes
- ☐ no privacy
- ☐ loving
- ☐ distant
- ☐ violence
- ☐ other descriptors:

What do you consider lo be the other stresses in your life? _____

_____

_____

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

_____

_____

Is the patient allergic to any medications? ___YES ___NO, If YES, please explain: _____

_____

Medications taken over an extended period of time? ___YES ___NO, If YES, please specify: _____

_____

MEDICAL INFORMATION CONTINUED:

Current prescription medication(s): _____

Has the client received any surgeries? ___YES ___NO, If YES, please specify: _____

_____

When was their last medical physical exam? _____

Does the patient exercise regularly? ___YES ___NO

Does the patient currently have any medical problems: ___YES ___NO If YES, please list: _____

_____

EARLY DEVELOPMENT

Development	Normal	Delayed
Sat up without help		
Crawled		
Walked alone		
Walked upstairs		
Rode a tricycle		
Caught a ball		
Spoke first words		
Put words together		
Spoke clearly for others		
Used fingers to feed self		
Used spoon		
Fully bowel trained		
Able to tie shoes		
Able to separate easily		

EARLY LIFE DIFFICULTIES

Y/N	CONDITION	Y/N	CONDITION
	Feeding difficulties		Loss of appetite, diarrhea, constipation
	Unwillingness to try new foods		Unpredictable appetite
	Extreme hunger		Colic
	Trouble falling asleep		Overactivity
	Very heavy sleeping		Head banging
	Rocking in bed		Temper tantrums
	Self-destructive behavior		Difficulty being comforted or consoled
	Stiffness or rigidity		Crying often and easily
	Shyness with strangers		Bashfulness with new children
	Irritability		Extreme reaction to noise
	Failure to be affectionate		Unwilling to go along with change
	Tendency to make odd sounds or grunts		Twitch or jerk heads/arms often

Please list any other early life difficulties: _____

_____

_____

SCHOOL HISTORY

Did the patient attend pre-school? ___YES ___NO

Were problems with behavior noted? ___YES ___NO

Were problems with learning noted? ___YES ___NO If YES, What age? _____

Was the client ever retained or recommended to be retained? ___YES ___NO

Does the client have difficulty making friends? ___YES ___NO

Does the client have difficulty keeping fiends? ___YES ___NO

Does the client prefer having younger or older friends? ___YES ___NO

Please give a brief social history: (divorce, loss, moves)

_____

_____

_____

_____