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: _____

CHILD INTAKE ASSESSMENT FORM (Ages 4 – 12)

STOKAN JAGGERS & ASSOCIATES
23501 Cinco Ranch Blvd., Ste. G270
Katy, Texas 77494
Office: 281-394-2005

FORM FILLED OUT BY: _____

Please answer all the following questions to the best of your ability.

IDENTIFYING INFORMATION

Name: _____ Today's Date: _____

Age: _____ D.O.B.: _____ Gender: _____

Name of Parents: _____

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 ___

_____

REASON FOR SEEKING TREATMENT

Please describe your greatest concerns for your child presently.

_____

_____

_____

What has happened to cause you to seek help NOW?

_____

_____

_____

_____

What goals do you have for your child, and what changes do you hope to see as a result of treatment? _____

_____

_____

_____

What do you consider to be the stressors in your child's life?

_____

_____

_____

_____

HISTORY OF THE PROBLEM

When did your child first experience the problem(s) that bring you to the clinic today?

_____

How often does the problem occur?

_____

How long does it last?

_____

Does your child currently have thoughts of harming him/herself? Yes ___ No ___

Does your child currently have urges to hurt or harm someone else? Yes ___ No ___

If yes, whom? _____

Has your child had previous therapy/counseling of any kind Yes ___ No ___

If yes, when and for how long? _____

_____

What concerns were addressed in previous therapy?

_____

_____

_____

Names and addresses of current or previous therapists: _____

_____

_____

Were any of the previous treatment experiences helpful? Yes ___ No ___

Please explain how your child benefited from previous treatment if applicable:

_____

_____

_____

Please explain any negative treatment experiences or ineffective treatments if applicable: _____

_____

_____

Please check any symptoms your child is currently or has recently experienced:

- ☐ Depression
- ☐ Extreme Mood Swings
- ☐ Forgetful
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Sleep Disturbances
- ☐ Hallucinations
- ☐ Difficulty Finishing Tasks
- ☐ Discipline Problems
- ☐ Poor Concentration
- ☐ Frequent Body Complaints
- ☐ Eating Disorder
- ☐ Body Image Problems
- ☐ Repetitive Thoughts (Obsessions)
- ☐ Repetitive Behaviors
- ☐ Argumentative
- ☐ Low Self Esteem
- ☐ Stress
- ☐ Impulsive Behaviors
- ☐ Anger
- ☐ Fears
- ☐ Rapid Speech
- ☐ Sadness
- ☐ Feeling Worthless
- ☐ Unmotivated
- ☐ Indecisiveness
- ☐ Grief
- ☐ Trouble Following Directions
- ☐ Learning Difficulties
- ☐ Vocal or Motor Tics
- ☐ Startled Easily
- ☐ Hyperactivity
- ☐ Fatigue
- ☐ Aggression
- ☐ Difficulty Making Friends
- ☐ Easily Distracted

Other: ☐ _____

Who else lives with your child? _____

HEALTH/MEDICAL INFORMATION

Is your child currently receiving any medical treatments? Yes ___ No ___

If yes, please describe and provide physicians name & phone number: _____

_____

Please list any significant medical problems/conditions, and indicate if your child is receiving treatment for them:

_____

_____

_____

_____

Do any of these problems affect his/her life? Yes ___ No ___ If yes, how?

_____

_____

Has your child ever had a serious head injury? Yes ___ No ___ If yes, please describe:

_____

_____

_____

List all medications that your child is currently taking:

_____
_____
_____

Please list any “alternative” therapies/treatments your child has experienced and the reason for each:

_____
_____
_____

INTERESTS AND ACTIVITIES

Please list any activities (such as sports, clubs, religious organizations, etc.) that your child is currently involved in:

_____
_____
_____

Please describe your child’s personal strengths and characteristics:

_____
_____
_____
_____

Other information you feel is important in helping your child receive effective treatment?

_____
_____
_____
_____

Your child’s comfort is very important, and some material is better discussed with them not present. Is there anything in the above information that you do not want your child to know? _____

_____

_____ _____

Client’s Signature **Date**