Complete & Return

Contract for Delivery of Professional Services

Debra Stokan, M.D.

Please read this document and initial each item as indicated:

- The fee for the initial evaluation for one-hour is $375
- The fee for an individual one-hour follow-up session is $300.
- The fee for a 40 min. medication management session is $240.
- The fee for a 20 min. medication management session is $175.
- The fee for telephone consultations is $175 per 20-minute unit.
- The fee for evaluation of records, special reports, and letters will be billed at the rate of $100
- Legal or Civil Case Involved: Each person responsible for payment for services must provide a retainer fee in the amount of $3,000.00; which will be held as a credit in client's account until termination of services. All services will be billed at the rate of $475.00 per hour, which includes all sessions, meetings, depositions, response to subpoenas, consultations, special reports, letters, phone calls, e -mail correspondence and any court appearance whether Dr. Debra Stokan testifies or not (includes transportation time both ways).

x_____ **I have read, and I understand and agree to the fees as outlined above.**

x_____ **Communication with my clinician:** I understand and agree to adhere to StokanJaggers & Associates policy in which all critical, time sensitive, appointment-related, medically-related, crisis-related or otherwise urgent or important communications where a response from my clinician is requested or expected MUST be made with and/or through the administrative staff, which includes the answering service that is available 24 hours a day, 7 days a week.

I further understand and agree that, at each clinician's discretion, and as a courtesy and convenience, communications between a client and their clinician *may* occur via email, texting, or personal voicemail. However, I further understand and agree that my clinician is not in any way obligated, responsible or liable for communicating with the clients in any of these ways nor for receiving, reading, or responding to any form of communication that occurs outside of Stokan Jaggers & Associates policy as stated above.

Note: If you want to be as certain as possible that your information, question or concern is communicated to your clinician, it must go through the administrative staff. For non-urgent or non-critical issues, it may take 24 to 48 weekday, non-holiday hours for the clinician to respond. If you need a response from your clinician and have not received one after 48 hours, it is the client's responsibility to contact the Stokan Jaggers & Associates office to follow up and verify that the intended communication did in fact occur

x_____ **Full payment is due at the time services are rendered** unless other written arrangements have been made in advance by me, my health coverage carrier, a co-responsible party or a third party who has agreed to pay fees for service rendered to me and has signed this contract. (pg 3)

x_____ I understand Stokan Jaggers & Associates does not have an arrangement with my health coverage carrier. It is my responsibility to pay in full at the time services are rendered and to file and collect my own insurance reimbursement. Stokan Jaggers & Associates will provide all reasonable information customarily needed to file a claim.

x_____ I **understand StokanJaggers & Associates 48-hour cancellation policy**, which applies to all appointments, must be cancelled or rescheduled through the administrative staff at least 48 hours in advance; however, Monday appointments must be cancelled *by* 9:00 a.m. the preceding Friday. I also understand and agree that failure to cancel or reschedule any appointment less than 48 hours in advance will require payment of the full fee as noted above.

x_____ I understand all cancellations and schedule changes must be made with the office staff either in person or by telephone, including messages left with Stokan Jaggers & Associates 24-hour answering service. **Note:** Please do not rely on e-mails or your clinician for communicating any schedule changes on your behalf to the office staff. Even if you and your clinician discuss and agree upon scheduling changes, your clinician IS NOT responsible for communicating that information to the staff. The client remains fully responsible for communicating that information to the administrative staff in accordance with the 48-hour cancellation policy.

x_____ I understand that all services rendered at Stokan Jaggers & Associates are charged differently and agree to pay the fees set forth. I understand that clinician's rates vary from one clinician to the other and agree to pay the fees established herein with this clinician. These services include telephone calls, medicine evaluation appointments, group therapy, telephone consultations, conference calls, educational, personality and psychological testing, co-therapy/feedback sessions, school visits, and social thinking instruction.

x_____ I understand and agree that in the case of divorced parents, unless otherwise agreed in writing in advance, the parent bringing the child to the office is responsible for payment at the time services are rendered.

x_____ I understand and agree that the adult accompanying a minor or the legal guardian will be responsible for payment at the time services are rendered.

Confidentiality: All information disclosed with my clinician is confidential and may not be revealed to anyone not affiliated with Stokan Jaggers & Associates without written permission except where disclosure is required by law. I hereby consent for Stokan Jaggers & Associates staff to consult with one another regarding my case.

Disclosure may be required in the following circumstances. Where there is a reasonable suspicion of child abuse or elder adult physical abuse; where there is a reasonable suspicion that the patient presents a danger of violence to others, or where the patient is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

I consent to services performed by StokanJaggers & Associates. My signature below indicates that I have read the above contract and agree to be bound to its terms.

Signature of Patient or Responsible Party if a Minor	Signature of Co-Responsible Party	Signature of Third-Party Guarantor
Date	Date	Date
Printed Name of the Patient	Signature of Clinician	Date

Addendum I

If you have signed the foregoing contract as a co-responsible party or a third party guarantor, your signature indicates that you have unconditionally promised to pay for all services determined by Stokan Jaggers & Associates to be psychologically or medically necessary, in the best interests of (name of client)

_____ and provided by Stokan Jaggers & Associates.

All payments are due by the co-responsible party or the third-party guarantor and shall be due and payable in the full amount and at each time set forth in this contract to which this acknowledgement and guarantee is attached.

_____ _____

Responsible Party Date Co-Responsible Party Date

Addendum II

The undersigned confirms that he/she is the sole managing conservator or joint managing conservator, guardian, guardian ad litem, next of kin, or other person with the court ordered right and duty to authorize the psychological or medically necessary treatment of _____. In connection with and simultaneously with the execution of this letter of authorization, I deliver to Stokan Jaggers & Associates copies of the following court orders:

a) Divorce Decree;
b) Order of Modification and an order SAPER (where applicable);
c) Temporary Order and a SAPER (where applicable);
d) Temporary Order (where applicable); and
e) Emergency Order (where applicable).

_____ _____

Responsible Party Date Co-Responsible Party Date

AUTHORIZATION
TO RELEASE MEDICAL RECORDS
TO MY INSURANCE COMPANY

Due to the influx of managed care, many insurance companies will request medical records before processing claims for you. To make the process faster, we ask that you check a box of your choice and sign below.

__ I authorize the release of my medical records to my insurance company.

___I do not authorize the release of my medical records to my insurance company.

In signing this authorization, it is my understanding that this information shall be held CONFIDENTIAL, that I do not waive the physician-patient privilege, and that the information will be utilized for professional use only. I do not authorize the person/company to whom these records are being forwarded to release them to any other person, company, or entity whatsoever.

At the time of request, your account will be charged for this request and your insurance company will be billed at the time records are sent.

_____
Patient Name

_____
Signature of Guarantor

_____
Date

Complete & Return

Stokan Jaggers & Associates
23501 Cinco Ranch Blvd., Ste. G270
Katy, TX 77494
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F: 281-394-5581
www.stokanjaggers.com

TEXAS NOTICE FORM

Notice of Mental Health Professionals' Policies and Practices to Protect the Privacy of Your Health Information

This is to confirm that I have read and understand the above noted form.

_____
Printed Name of Client

_____ _____
Signature of Client or Responsible Party Date

_____
Printed Name of Responsible Party

SJ &A | STOKAN JAGGERS & ASSOCIATES

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:

_____

Credit Card Type: VISA, MASTER CARD, DISCOVER, AMEX

Credit Card Number: _____

Expiration Date: _____

Security Code (CVV): _____

Address: _____

Name as it appears on card: _____

Authorized by: _____ Date: _____
Signature

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www.stokanjaggers.com

STOKAN JAGGERS & ASSOCIATES
WELCOME TO OUR OFFICE!

DATE:_____

PATIENT INFORMATION:

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____ SEX: ___M ___F

HOME PHONE: _____

MAY WE LEAVE A MESSAGE? YES ___ NO___

CELL/OTHER PHONE: _____

MAY WE LEAVE A MESSAGE? YES___ NO___

E-MAIL: _____ MAY WE EMAIL YOU? YES____ NO_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

DATE OF BIRTH:_____ AGE: _____

SPOUSE NAME:_____
FIRST MIDDLE LAST

SPOUSE CELL #:_____

IN CASE OF AN EMERGENCY, CALL:_____

OTHER FAMILY MEMBERS:

NAME	AGE	RELATION
1.		
2.		
3.		
4.		

PATIENT'S MEDICAL DOCTOR:_____ PHONE #:_____

WHY IS THE PATIENT COMING IN FOR CONSULTATION?

_____

MEDICAL INFORMATION:

HAVE YOU EVER RECEIVED PSYCHIATRIC OR COUNSELING SERVICES BEFORE? YES__ NO__

IF YES, PLEASE LIST FOR WHAT:

ARE THERE ANY MEDICAL ILLNESSES THAT RUN IN YOUR FAMILY? YES___ NO___

IS THERE ANYONE IN YOUR FAMILY WHO HAS:

LIST FAMILY MEMBER:

____ ANXIETY OR DEPRESSION

____ ABUSED ALCOHOL OR OTHER DRUGS

____ ANY PSYCHIATRIC ILLNESS

____ SEIZURES OR OTHER NEUROLOGICAL PROBLEMS

____ TOURETTE'S SYNDROME OR TICS

____ HEART PROBLEMS

____ THYROID PROBLEMS

____ HIGH BLOOD PRESSURE

____ ATTENTIONAL PROBLEMS

____ LEARNING DISABILITIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES____ NO____

IF YES, PLEASE LIST:

WHEN WAS YOUR LAST PHYSICAL EXAM: _____

DO YOU EXERCISE REGULARLY? YES___ NO___

DO YOU CURRENTLY HAVE ANY MEDICAL PROBLEMS: YES___ NO____
IF YES, PLEASE LIST:

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

___ HOSPITALIZED MEDICALLY(INCLUDING PSYCHIATRIC)

___NAUSE OR VOMITING

___HEART PROBLEMS

___VISION PROBLEMS

___HIGH BLOOD PRESSURE

___INJURY TO HEAD

___THYROID PROBLEMS

___LOSS OF APPETITE, DIARRHEA, CONSTIPATION

___ULCERS

___LIVER DISEASE

___SEIZURES

___CHEST PAIN OR SHORTNESS OF BREATH

___ENCEPHHALITIS

___SLEEP PROBLEMS

___RECENT WEIGHT CHANGES

___UNUSUAL OR EXCESSIVE BLEEDING

___DEPRESSION

___CHANGE IN LIBIDO

___SEEN A COUNSELOR OR PSYCHIATRIST

___ANXIETY

DO YOU TAKE ANY MEDICATIONS? YES___ NO___

IF YES, PLEASE LIST MEDICATION, DOSAGE AND TIME OF DAY TAKEN:

FOR FEMALES ONLY:
DO YOU USE BIRTH CONTROL? YES___ NO___
ARE YOU TRYING TO GET PREGNANT? YES___ NO___
DO YOU INTEND TO GET PREGNANT WITHIN THE NEXT 5 YEARS? YES___ NO___
ARE YOU CURRENTLY NURSING? YES___ NO___

FAMILY RELATIONSHIPS:

MARITAL STATUS::

___NEVER MARRIED ___DOMESTIC PARTNERSHIP ___MARRIED

___SEPARATED ___DIVORCED ___WIDOWED

DO YOU HAVE ANY CHILDREN YES____ NO_____

NAME: AGE: QUALITY OF RELATIONSHIP:

EXTENDED FAMILY:

PARENTS:_____
AGE:_____ ALIVE/DECEASED:_____
QUALITY OF RELATIONSHIP:_____

SIBLINGS:
NAME: AGE: QUALITY OF RELATIONSHIP:

DEVELOPMENTAL HISTORY:

AS FAR AS YOU KNOW, DID YOUR MOTHER HAVE ANY DELIVERY OR PREGNANCY ISSUES?
YES___ NO___

AS FAR AS YOU KNOW, DID YOU HAVE ANY DIFFICULTY LEARNING TO WALK, TALK OR SIT UP?
YES___ NO___

WERE YOU DIFFICULT TO CONTROL AS A CHILD?
YES___ NO___

DID YOU HAVE DIFFICULTIES SLEEPING?
YES___ NO___

DID YOU HAVE NORMAL RELATIONSHIPS WITH PEERS?
YES___ NO___

DID YOU REMEMBER HAVING A LOT OF ANXIETIES OR WORRIES AS A CHILD?
YES___ NO___

SCHOOL HISTORY:

DID YOU HAVE ANY PROBLEMS IN SCHOOL? YES___ NO___

ANY DIFFICULTIES FOCUSING IN SCHOOL? YES___ NO___

WERE YOU IN SPECIAL CLASSES? YES___ NO___

DID YOU ACHIEVE THE GRADES YOU EXPECTED OR DESIRED? YES___ NO___

HOW WERE YOUR GRADES?
WORSE THAN AVERAGE: ____
AVERAGE: ____
ABOVE AVERAGE: _____

DRUG/ALCOHOL USAGE:

HOW MUCH CAFFEINE DO YOU DRINK?

_____

HOW MUCH ALCOHOL DO YOU DRINK IN A WEEK?

_____

DO YOU DO DRUGS? YES___ NO___

IF YES, PLEASE INDICATE WHICH OF THESE SUBSTANCES YOU CURRENTLY USE:

CIGARETTES ___
ALCOHOL ___
PILLS NOT PRESCRIBED TO ME ___

MARIJUANA ___
COCAINE OR CRACK ___
LSD ___
HEROIN ___
OTHER _____

ARE CURRENTLY EXPERIENCING ANY CHRONIC PAIN? YES___ HOW OFTEN?_____ NO___

EMOTIONAL HISTORY:

HOW WOULD YOU DESCRIBE YOUR MOOD?
_____

DO YOU HAVE PROBLEMS WITH YOUR TEMPER? YES___ NO___

HAVE YOU EVER LOST YOUR TEMPER ENOUGH TO HURT ANYONE OR DAMAGE PROPERTY?
YES___ NO___

DO OTHERS COMPLAIN ABOUT YOUR TEMPER?
YES___ NO___

DO YOU HAVE RELATIONSHIP ISSUES?
YES___ NO___

___ For a hard copy HIPPA, please check here.