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
P: 281-394-2005
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:

CHILD'S NAME:________________________________ SCHOOL:_______________________

ADDRESS:______________________________ BIRTHDAY:__________ AGE: ______

CITY:__________________________ STATE:______ ZIP CODE:____________ SEX: ____M ____F

**PLEASE LIST ALL FAMILY MEMBERS WHO HAVE HAD OR CURRENTLY HAVING TREATMENT HERE:

____

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.

MOTHER'S NAME: ____________________________ FATHER'S NAME:_______________________

STEP FATHER: ______________________________ STEP MOTHER:_________________________

IN CASE OF AN EMERGENCY:____

RESPONSIBLE PARTY:

NAME:____ RELATIONSHIP:________________

ADDRESS:____

CITY:__________________________ STATE:______ ZIP CODE:____________

EMAIL:____

PATIENT'S MEDICAL DOCTOR:______________________________ PHONE #:__________________

WHY IS THE PATIENT COMING IN FOR CONSULTATION?

____

____

____

____

AT WHAT AGE WAS THIS PROBLEM FIRST NOTED? __________

IN WHAT AREAS DOES THE PROBLEM INTERFERE WITH YOUR CHILD'S EVERYDAY FUNCTIONING?

____

____

HAS YOUR CHILD EVER BEEN EVALUATED OR TESTED BEFORE? YES___ NO___

IF YES, PLEASE EXPLAIN: ____

BIRTH HISTORY:

IS YOUR CHILD ADOPTED? YES___ NO___ WHAT AGE IF YES? ___

ANY DIFFICULTIES DURING PREGNANCY? YES___ NO___

IF YES, PLEASE EXPLAIN: ____

BIRTH WEIGHT: _____

INFECTION? YES___ NO___
CORD AROUND NECK? YES__ NO__
INJURIES DURING BIRTH? YES___ NO__
DIFFICULTY FEEDING? YES___ NO___

REQUIRED OXYGEN? YES___ NO___
INCUBATOR? YES___ NO___
JAUNDICED? YES___ NO___

MEDICAL INFORMATION:

ARE THERE ANY MEDICAL ILLNESSES THAT RUN IN YOU 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

HAS THE PATIENT EVER EXPERIENCED:

HEAD INJURY ? YES___ NO___
LOSS OF CONSCIOUSNESS? YES__ NO__
MOTOR TICS OR VOCALIZATIONS? YES___ NO___
EAR INFECTIONS? YES___ NO___
P.E. TUBES? YES___ NO___
MENINGITIS? YES___ NO___
SLOW WEIGHT GAIN? YES___ NO___
HEART PROBLEMS? YES___ NO___
GENETIC OR CONGENITAL CONDITIONS? YES___ NO___
OTHER: ____

ARE THEY ALLERGIC TO ANY MEDICATIONS? YES____ NO____

IF YES, PLEASE LIST:

____

MEDICATIONS TAKEN OVER AN EXTENDED PERIOD OF TIME? PLEASE SPECIFY.______________________________

CURRENT PRESCRIBED MEDICATION:______________________________

HAS THE CLIENT RECEIVED ANY SURGERIES? PLEASE SPECIFY.______________________

WHEN WAS THEIR LAST PHYSICAL EXAM: ______________________________

DO THEY EXERCISE REGULARLY? YES___ NO___

DO THEY CURRENTLY HAVE ANY MEDICAL PROBLEMS: YES___ NO___
IF YES, PLEASE LIST:

EARLY 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 A SPOON	______	______
FULLY BOWEL TRAINED	______	______
ABLE TO DRESS SELF	______	______
ABLE TO TIE SHOELACES	______	______
ABLE TO SEPARATE EASILY	______	______

EARLY LIFE DIFFICULTIES

___ FEEDING DIFFICULTY
___UNWILLINGNESS TO TRY NEW FOODS
___EXTREME HUNGER
___TROUBLE FALLING ASLEEP
___VERY HEAVY SLEEPING
___ROCKING IN BED
___SELF DESTRUCTIVE BEHAVIOR
___STIFFNESS OR RIGIDITY
___SHYNESS WITH STRANGERS
___IRRITABILITY
___FAILURE TO BE AFFECTIONATE
___TENDENCY TO MAKE ODD SOUNDS, GRUNTS OR SNORTS
___LOSS OF APPETITE, DIARRHEA, CONSTIPATION
___UNPREDICTABLE APPETITE
___COLIC
___OVER ACTIVITY
___HEAD BANGING
___TEMPER TANTRUMS
___DIFFICULTY IN BEING COMFORTED OR CONSOLED
___CRYING OFTEN AND EASILY
___BASHFULNESS WITH NEW CHILDREN
___EXTREME REACTION TO NOISE
___UNWILLING TO GO ALONG WITH CHANGE
___ TWITCH OR JERK HEADS/ARMS OFTEN

PLEASE NOTE ANY OTHER DIFFICULTIES:

SCHOOL HISTORY:

DID CLIENT 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 FRIENDS? YES___ NO___

DOES THE CLIENT PREFER HAVING YOUNGER OR OLDER FRIENDS? ____________________

PLEASE GIVE BRIEF SOCIAL HISTORY: (DIVORCE, LOSS, MOVES)

____

____

____

____

** ___ For a hard copy HIPPA, please check here.