

**Stokan Jagers & Associates**  
23501 Cinco Ranch Blvd., Ste. G270  
Katy, Texas 77494

Dr. Karen Jagers, LPC

## **Client - Therapist Agreement**

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 with regard to 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 will 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. In order 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, or 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 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 (business days), you will 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 \$250.00 for the initial intake session and \$185.00 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 charge a higher fee for my professional 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.

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

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

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

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

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

**ADOLESCENT INTAKE ASSESSMENT FORM (Ages 13 - 18)**  
*Parent Version*

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

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

**IDENTIFYING INFORMATION**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please explain any negative treatment experiences or ineffective treatments?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check any symptoms that you believe your child is currently or has recently experienced in the below section:

Depression:

Forgetful:

Panic Attacks:

Sleep Disturbances:

Extreme Mood Swings:

Anxiety:

Phobias:

Hallucinations:

- Difficulty Finishing Tasks:
- Poor Concentration:
- Eating Disorder:
- Repetitive Thoughts (Obsessions):
- Argumentative:
- Stress:
- Impulsive Behaviors:
- Anger:
- Rapid Speech:
- Feeling Worthless:
- Indecisiveness:
- Trouble Following Directions:
- Vocal or Motor Tics:
- Hyperactivity:
- Aggression:
- Suicidal Thoughts:
- Easily Distracted:
- Substance Abuse:

- Discipline Problems:
- Frequent Body Complaints:
- Body Image Problems:
- Repetitive Behaviors:
- Low Self Esteem:
- Spiritual Problems:
- Self-Destructive Behavior
- Fears:
- Sadness:
- Unmotivated:
- Grief:
- Learning Difficulties:
- Startled Easily:
- Fatigue:
- Difficulty Making Friends
- Loneliness:
- Loss of Appetite:
- Other:  \_\_\_\_\_

- Are they currently experiencing any suicidal thoughts?  Yes  No
- Have they ever experienced suicidal thoughts in the past?  Yes  No
- Have they attempted suicide in the past?  Yes  No
- Are they currently experiencing any violent or homicidal thoughts?  Yes  No

**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 so, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medications that your child is currently taking:

Name	Dosage	Symptom Treated

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

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**INTERESTS AND ACTIVITIES**

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

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Please describe your child's personal strengths and characteristics:

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

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Thank you for taking the time to complete this questionnaire.  
Please feel free to add any additional information that you feel would be helpful.

**ADOLESCENT INTAKE ASSESSMENT FORM (Ages 13 – 18)**  
*Adolescent Version*

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

\*\*\* Parent: Please have your teenager complete this version of the form on their own.

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

**IDENTIFYING INFORMATION**

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth Order (circle one):    oldest    middle    youngest

Please list any medications you are currently taking: \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Who do you live with?    Mom: Y \_\_\_\_ N \_\_\_\_    Dad: Y \_\_\_\_ N \_\_\_\_

Who else lives in your home?

Name	Relationship (sibling, step parent, etc.)	Age

How are you doing in school? \_\_\_\_\_

What are your grades? \_\_\_\_\_ Do you like it? \_\_\_\_\_

Extracurricular Activities: \_\_\_\_\_

\_\_\_\_\_



Do you ever skip class? Y \_\_\_\_ N \_\_\_\_ Ever been expelled? Y \_\_\_\_ N \_\_\_\_

If yes, for what? \_\_\_\_\_

Have your grades gotten better or worse lately? If so, why? \_\_\_\_\_

### REASON FOR SEEKING TREATMENT

Please describe your greatest concerns at this time. \_\_\_\_\_

What has happened to cause you to seek help NOW?

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

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

### HISTORY OF THE PROBLEM

When did you first experience the problem(s) that bring you here today?

How often does the problem occur?

How long does it last?

Have you had previous therapy/counseling of any kind?  Yes  No

If yes, when and for how long?

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What concerns were addressed in previous therapy?

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Names and addresses of current or previous therapists:

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Were any of the previous treatment experiences helpful?  Yes  No

Please explain how you benefited from previous treatment:

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Please explain any negative treatment experiences or ineffective treatments?

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**Please check any symptoms that you are currently or have recently experienced in the below section:**

Depression:

Forgetful:

Panic Attacks:

Sleep Disturbances:

Difficulty Finishing Tasks:

Poor Concentration:

Eating Disorder:

Repetitive Thoughts (Obsessions):

Argumentative:

Stress:

Impulsive Behaviors:

Anger:

Rapid Speech:

Extreme Mood Swings:

Anxiety:

Phobias:

Hallucinations:

Discipline Problems:

Frequent Body Complaints:

Body Image Problems:

Repetitive Behaviors:

Low Self Esteem:

Spiritual Problems:

Self-Destructive Behavior

Fears:

Sadness:

Feeling Worthless:

Indecisiveness:

Trouble Following Directions:

Vocal or Motor Tics:

Hyperactivity:

Aggression:

Suicidal Thoughts:

Easily Distracted:

Substance Abuse:

Unmotivated:

Grief:

Learning Difficulties:

Startled Easily:

Fatigue:

Difficulty Making Friends:

Loneliness:

Loss of Appetite:

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

If yes, how many times and when? \_\_\_\_\_

Are you currently experiencing urges to hurt or harm someone else?  Yes  No

If yes, whom? \_\_\_\_\_

#### HEALTH/MEDICAL INFORMATION

Are you currently receiving any medical treatments?  Yes  No

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

\_\_\_\_\_

Please list any other significant medical problems/conditions:

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

List all medications that you are currently taking:

Name	Dosage	Symptom Treated

Please list any "alternative" therapies/treatments you have experienced and the reason for each:

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#### INTERESTS AND ACTIVITIES

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

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Please describe your personal strengths and characteristics:

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

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Thank you for taking the time to complete this questionnaire.

Please feel free to add any additional information that you feel would be helpful.