Contract for Delivery of Professional Services
Debra Stokan, M.D.

23501 Cinco Ranch Blvd., Ste. G270, Katy, TX 77494
Office: 281-394-2005

Please read this document and initial each item as indicated:

- The fee for the initial evaluation for one-hour is $450.
- The fee for an individual one-hour follow-up session is $325.
- The fee for a40 min. medication management session is $265.
- The fee for a 20 min. medication management session is $200.
- The fee for telephone consultations is $200 per 20-minute unit.
- The fee for evaluation of records, special reports, and letters will be billed at the rate of $125.
- Legal or Civil Case Involved: Each person responsible for payment for services must provide a retainer fee in the amount of $4,000.00, which will be held as a credit in client's account until termination of services. All services will be billed at the rate of $750 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 Stokan & 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 & 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 48 to 72 hrs 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 & 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. (pg3)

x I understand Stokan & 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 & Associates will provide all reasonable information customarily needed to file a claim.

x I **understand Stokan & 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 & 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 & 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 & Associates without written permission except where disclosure is required by law. I hereby consent for Stokan & 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 Stokan & Associates. My signature below indicates that I have read the above contract and agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____ _____

Signature of Co-Responsible Party Date

_____ _____

Signature of Third-Party Guarantor Date

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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

___ Please check here for a hard copy of HIPPA.

CREDIT CARD AUTHORIZATION FORM

We accept HSA/FSA, Visa, Master Card, American Express, and Discover Cards.
Payment is rendered at the 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 & Associates as a provider of services for:

_____

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

Credit Card Number: _____

Expiration Date: _____ Security Code (CVV): _____

Address: _____

Name as it appears on card: _____

Signature: _____ Date: _____

2nd Credit Card Type: VISA, MASTER CARD, DISCOVER, AMEX

Credit Card Number: _____

Expiration Date: _____ Security Code (CVV): _____

Address: _____

Name as it appears on card: _____

Signature: _____ Date: _____

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Taken by: _____ ***Date:*** _____

Dr. Stokan – Child In-take Information

Today's DATE:_____

PATIENT INFORMATION:

Name: _____

Date of Birth: _____ Age: _____ Gender: ___ M ___ F

Home Address_____

City:_____ State: _____ Zip Code: _____

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

_____

Home Phone: _____ LEAVE A MESSAGE: ___YES ___NO

Cell Phone: _____ LEAVE A MESSAGE: ___YES ___NO

Email: _____ LEAVE A MESSAGE: ___YES ___NO

Please note email correspondence is not considered to be confidential medium of communication

Mother's Name: _____ Father's Name: _____

Stepfather: _____ Stepmother: _____

In Case of Emergency: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____ Relationship: _____

Home Address: _____

City:_____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Patient's Medical Doctor: _____ Phone: _____

Why is the patient seeking consultation? _____

_____

At what age was this problem first noted? _____

In what areas of life 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 INFORMATION:

Is your child adopted? ___YES ___NO, if YES, what age? _____

Any difficulties during pregnancy? ___YES ___NO, If YES, please explain: _____

_____

Birth weight: _____

Y/N	BIRTH CONDITION	Y/N	BIRTH CONDITION
	Infection		Required oxygen
	Cord around neck		Incubator
	Injuries during birth		Jaundiced
	Difficulty feeding		Other:

MEDICAL INFORMATION:

Are there any medical illnesses that run in your family? _____ YES ___NO

Is there anyone in your family who has:

Y/N	CONDITION	LIST FAMILY MEMBERS
	Anxiety or depression	
	Abused alcohol or 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 this?

Y/N	CONDITION	Y/N	CONDITION
	Head injury		Meningitis
	Loss of consciousness		Slow weight gain
	Motor tics or vocalizations		Heart problems
	Ear infections		Genetics or congenital conditions
	P.E. tubes		Other

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 been 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? ___YES ___NO

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

_____

_____

_____

_____