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

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

___ 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: _____

==========

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

Dr. Stokan – Adult In-take Information

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

Spouse Name: _____

Spouse Cell Phone: _____

In Case of an Emergency, Call: _____

Other Family Members:

	Name	Age	Relationship
1.	_____		
2.	_____		
3.	_____		
4.	_____		

Patient's Medical Doctor: _____ Phone: _____

Why is the patient coming for consultation?

_____

_____

MEDICAL INFORMATION:

Have you ever received psychiatric or counseling services? ___YES ___NO

If YES, please list for what:

_____

_____

Are you allergic to any medications? ___YES ___NO

If YES, please list:

_____

When was your last medical 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:

Y/N	CONDITION	Y/N	CONDITION
	Hospitalized medically (including psychia		Ulcers
	Nausea of vomiting		Loss of appetite, diarrhea, constipation
	Heat problems		Live Disease
	High blood pressure		Seizures
	Injury to head		Chest pain or shortness of breath
	Thyroid problems		Encephalitis
	Vision problems		Sleep problems
	Recent weight change		Change in libido
	Unusual or excessive bleeding		Seen a counselor or psychiatrist
	Depression		Anxiety

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	

MEDICAL INFORMATION CONTINUED:

Do you take any medication? ___YES ___NO

If YES, please list:

_____

_____

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 five 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

Children's Name	Age	Quality of Relationship

EXTENDED FAMILY:

Parent's Name: _____

Alive/Deceased: _____ Age: _____

Quality of relationship: _____

SIBLINGS:

Sibling's 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 difficulties learning to walk, talk, or sit up? ___YES ___NO

Were you difficult to control as a child? ___YES ___NO

Did you have difficulties sleeping as a child? ___YES ___NO

Did you have normal relationships with peers as a child? ___YES ___NO

Do 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 education classes? ___YES ___NO

Did you achieve the grades you expected or desired? ___YES ___NO

How were your grades in school? _____ Worse than average ____ Average ____ Above Average

DRUG/ALCOHOL USAGE:

How much caffeine do you drink per day? _____ per week? _____

How much alcohol do you drink in a day? _____ in a week? _____

Do you do drugs? ___YES ___NO

If YES, please indicate which of these substances you currently use?

Y/N	DRUG
	Cigarettes
	Medication pills not prescribed to you
	Marijuana
	Cocaine or Crack
	LSD
	Heroin
	Other

Are you currently experiencing any chronic pain? ___YES ___NO, If YES, how often? _____

EMOTIONAL HISTORY:

How would you describe your mood? _____

_____

_____

_____

Do you have problems with your temper? ___YES ___NO

Have you ever lost your tempter enough to hurt anyone or damage property? ___YES ___NO

Do others complain about your temper? ___YES ___NO

Do you have difficulty maintaining relationships? ___YES ___NO