

# Lesley Stabinsky Compton, PhD

## Information, Policies, and Consent

(Revised January 1, 2020)

We are honored that you have selected Woodlands Family Institute, P.C. to provide counseling or psychological services. All of us do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my practice policies and to ensure that you understand our professional relationship.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

## Office Policies

### Psychotherapy

This document provides important information about my professional services and business policies. Your signature in reference to this form will indicate that you have received this information, have read it, understand it, and agree to it.

If you have concerns or questions, please feel free to ask me about them.

### Sessions

Therapy sessions are scheduled for 50 minutes, unless otherwise planned in advance. I make every effort to start appointments on time. The session time that we have scheduled is reserved for you. If you are not able to keep an appointment, I ask you to give me at least 24 hour notice. Sessions not cancelled with 24 hour notice will be charged my standard rate.

### Standard Rate

\$175.00 per 50 minute session.

Charges for other professional services, such as phone calls, insurance reports, third-party consultations, and correspondence will be prorated on the basis of \$175.00 per hour. Off-site consultation is charged at the rate of \$175.00 per hour, portal to portal.

**Forensic Rates**

\$600.00 per hour (portal to portal) for court testimony or deposition. Payment is due 24 hours prior to services provided.

**Payment Policy**

Payment is due at the time of service. The office accepts checks, cash, Visa and Master Card. It is not our policy to carry balances forward. We expect balances to be made up promptly or by the next regularly scheduled appointment. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling fee for every statement sent out after the first billing. There is also a \$25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. Although I am not listed as a provider on any insurance network panels, benefits are sometimes available for services rendered by “out-of-network” providers. I advise that you contact your insurance company to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier for services rendered, the office will provide you with a receipt to assist you in completing your insurance claim. We will consult your third-party payer only at your direction with such consultations billed to your account. The client remains responsible for payment in full.

**Cancellations**

Since the scheduling of an appointment involves the reservation of time specifically for you, 24 hour advance notice for any cancelled appointments will not be charged. If you do not meet this time schedule, please expect to be charged the regular session fee for that appointment.

**Office Hours**

My normal office hours are 8 a.m. to 6 p.m. on Tuesdays and Wednesdays.

**Emergencies**

If you are experiencing a life threatening emergency please call 911. In the event of an emergency that is not life threatening, leave a message with the answering service, making sure to state that your call is an emergency. I will respond to your call as promptly as possible. The office phone is 281-363-4220 or 713-866-4494.

**Contacting Me**

Due to my work schedule, I am often not immediately available by telephone. I will make every effort to return your call on the same day that you make it, with the exceptions of weekends and holidays.

I use email, cell phone, and texting for scheduling and occasional between-session contact. I do not use these means of communications to discuss therapeutic topics or issues. I will respond to emails within 1-5 days. Do not use email or text messaging to contact me about urgent matters. My email account is secure and encrypted. However, while my email is secure, yours may not be.

I do not have a professional Facebook page, but I do have a personal Facebook profile. I do not accept friend requests from current clients. If you request to be added as a “friend” to my personal Facebook page, please note that this request will not be confirmed. The American Psychological Association has very strict guidelines with regard to contact between a psychologist and a client outside of a professional relationship.

**Confidentiality**

You should be aware that I practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client’s identity. Any other professional consulted is also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. We also have contacts with some business services, such as the answering service, electronic claims processing services, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available on request.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about ones physical, emotional, or mental condition; g) when disclosure is relevant in any law suit affecting the parent-child relationship; h) where otherwise legally required. If you are under 18, your parents or legal guardians(s) may have access to your records and may authorize their release to other parties.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be not absolute guarantee of cure in the practice of psychotherapy.

\_\_\_\_\_  
**CLIENT’S SIGNATURE**

\_\_\_\_\_  
**DATE**

## Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

**After reading the agreements, please ask about any part of the agreement that you do not understand.**

## PERSONAL DATA RECORD

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

SSN \_\_\_\_\_ TXDL \_\_\_\_\_

Employer/School/Address \_\_\_\_\_

### **May we leave a message at any of the following?**

Cell phone (circle one) \_\_\_\_\_ Yes No

Work phone (circle one) \_\_\_\_\_ Yes No

Unencrypted email address \_\_\_\_\_ Yes No

**\* Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other \_\_\_\_\_

### ***CONSENT FOR TREATMENT***

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I give full consent for ***myself, my child/adolescent or dependent*** due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.**

Cardholder's Name \_\_\_\_\_ Relationship \_\_\_\_\_

MC/VISA/DISC No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature of Authorized User \_\_\_\_\_

Use for **regular** sessions, after hours, missed or late cancel sessions

**Financial Responsibility**

Name of person(s) financially responsible for this account \_\_\_\_\_

Address/phone if different from client \_\_\_\_\_

\_\_\_\_\_

Signature(s) \_\_\_\_\_

Relationship to client \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Alternate phone \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

Relationship to client \_\_\_\_\_

**Referred** to our office by \_\_\_\_\_

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

## Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): \_\_\_\_\_

Your email address: \_\_\_\_\_

Your cell number: \_\_\_\_\_

Where would you like to receive appointment reminders? (Check one)

Via text message on my cell phone (normal text message rates will apply)

Via email message to the address listed above

Via automated voice mail message on my cell phone

**\*\*Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.\*\***

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### {Please refer to pages 8-9 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

\_\_\_\_\_  
Client or Authorized Representative Signature

\_\_\_\_\_  
Date

Refuse to Sign       Unable to Sign (specify reason) \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Documenting Refusal or Inability to Sign

\_\_\_\_\_  
Date

## Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute, P.C. may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your general consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”  
*Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.  
*Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.  
*Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within WFI such as utilizing information that identifies you.
- “Disclosure” applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker’s Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.

#### **IV. Client's Rights and Our Professional Duties**

##### Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

#### **V. Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

Adult Intake Form

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Identifying Information/Presenting Problem:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Date of Evaluation/Intake \_\_\_\_\_

Who referred you \_\_\_\_\_

Presenting Problem \_\_\_\_\_

\_\_\_\_\_

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Family History:

Current Members of the Household:

| Name | Age | Relationship | How do they get along with others in home? |
|------|-----|--------------|--|
|------|-----|--------------|--|

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

Describe your relationships with household members: \_\_\_\_\_

\_\_\_\_\_

Number of children and ages: \_\_\_\_\_

Where are any children outside of the home?: \_\_\_\_\_

\_\_\_\_\_

Are you currently married or with a partner? \_\_\_\_\_ Length of this relationship? \_\_\_\_\_

History of separations or divorce? \_\_\_\_\_

Describe what your relationships have been like with significant others (partners) \_\_\_\_\_

\_\_\_\_\_

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Parenting:

How do you view your parenting skills? \_\_\_\_\_

What do you need to improve as a parent? \_\_\_\_\_

What do you use for discipline? \_\_\_\_\_

Have you used physical discipline? Explain: \_\_\_\_\_

Have you ever had problems providing the basic needs for your children (utilities, food, clothing, housing)

Describe: \_\_\_\_\_

Family of Origin:

Please describe your childhood: \_\_\_\_\_

Describe your current and past relationship with your mother: \_\_\_\_\_

Describe your current and past relationship with your father: \_\_\_\_\_

Does either of your parents (or caregivers) have drug or alcohol use/abuse now or in the past?

Describe: \_\_\_\_\_

Does either of your parents (or caregivers) have domestic violence issues or significant conflict? Describe: \_\_\_\_\_

How many brothers and sisters do you have? Describe your relationships with siblings?

Does anyone in your extended family (siblings and parents) have a history of mental health problems? Describe: \_\_\_\_\_

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History of Trauma:

Please check and describe any of following that have occurred anytime in your life, either as the victim or as a witness:

( ) Physical Assault or Abuse: \_\_\_\_\_

( ) Emotional Abuse: \_\_\_\_\_

( ) Domestic Violence or Exposure to Physical Conflicts: \_\_\_\_\_

( ) Neglect (Not having basic needs met): \_\_\_\_\_

( ) Sexual Abuse: \_\_\_\_\_

Describe anything else you have experienced that may have been traumatic or greatly impacted you in your life: \_\_\_\_\_

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Social/Emotional Functioning

Describe your personality: \_\_\_\_\_

What would you like to change about yourself? \_\_\_\_\_

How do you deal with frustration?: \_\_\_\_\_

Do you feel you have anger issues? Describe: \_\_\_\_\_

What are your strengths?: \_\_\_\_\_

What are your weaknesses? \_\_\_\_\_

What are your fears (what are you afraid of)? \_\_\_\_\_

How many close friends do you have? \_\_\_\_\_ What do you do with friends? \_\_\_\_\_

Describe your relationships with others: \_\_\_\_\_

How do you spend your free time? \_\_\_\_\_

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### Legal History

Please list and explain any legal charges you have had (even if the charges were reduced or dropped), include dates: \_\_\_\_\_

Have you ever been: ( ) on probation ( ) on parole ( ) incarcerated. Provide reason and dates: \_\_\_\_\_

Please describe if you have any family or friends (current or past) that have legal charges: \_\_\_\_\_

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### Substance Use:

How often do you drink alcohol? \_\_\_\_\_ How much per sitting? \_\_\_\_\_

Have you ever used or abused any drugs in your life? Describe: \_\_\_\_\_

Have you ever had any treatment related to substance use? Describe: \_\_\_\_\_

Do you smoke cigarettes? ( )Yes ( )No Amount per day? \_\_\_\_\_

Please indicate if you have any family or close friends (current or past) who have an alcohol or drug problem: \_\_\_\_\_

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### Medical History:

Significant medical problems during childhood: \_\_\_\_\_

Current health and medical problems: \_\_\_\_\_

(Past: include age): \_\_\_\_\_

Current medications: \_\_\_\_\_

Past medications for behavioral/emotional problems: \_\_\_\_\_

Other medical history: \_\_\_\_\_

Describe your sleeping patterns: \_\_\_\_\_

Is there a history of nightmares? (Describe): \_\_\_\_\_

Describe your eating patterns: \_\_\_\_\_

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Mental Health History:

What current mental health services (counseling and/or psychiatrist) are you receiving?

\_\_\_\_\_

What mental health services have you received in the past? (include dates)

\_\_\_\_\_

What have you been diagnosed with (current or past)?

Have you ever received a psychological assessment in the past?

Date: \_\_\_\_\_ Results of testing: \_\_\_\_\_

Have you ever thought about or attempted to harm yourself or someone else?

Describe: \_\_\_\_\_

\_\_\_\_\_

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Employment & Educational History:

Current Employment: \_\_\_\_\_

Amount of time at current employment: \_\_\_\_\_

How many hours do you work in a typical week? \_\_\_\_\_

If not employed, how long have you been without work and explain why? \_\_\_\_\_

\_\_\_\_\_

How many jobs have you had in the last 5 years? (describe): \_\_\_\_\_

Describe your current level of job satisfaction: \_\_\_\_\_

Describe your relationship with others at your job: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Did you have any learning difficulties in school? \_\_\_\_\_

Did you have frequent discipline problems while in school? Explain: \_\_\_\_\_

\_\_\_\_\_

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Daily Living:

Describe your daily activities: \_\_\_\_\_

\_\_\_\_\_

Do you have difficulties managing money? \_\_\_\_\_

Number of hours your watch television or use computer for leisure per day: \_\_\_\_\_

How many different homes have you lived in over the last 5 years? \_\_\_\_\_

Is there any history of developmental delays, explain: \_\_\_\_\_

**Please check all symptoms that apply:**

- Learning Problems
- Social Isolation
- Depressed Mood
- Lack of Pleasure in Activities
- Obsession with Specific Topics/Thoughts/Actions/ Behaviors
- Weight Loss or Gain
- Appetite Loss or Gain
- Insomnia or Oversleeping
- Attention Problems
- Loss of Energy or Excessive Energy
- Feelings of Worthlessness or Guilt
- Thoughts of Death
- Nervousness or Anxiety
- Irritability or Anger
- Hearing or Seeing Things that Other People Do Not Hear or See
- Excessive Worrying
- Recent Life Transition
- Suicidal thoughts, gesture, or attempt
- Homicidal thoughts
- Self-abusive behavior
- Substance abuse
- Other

*{Your clinician will discuss the following items with you upon your initial session, and periodically thereafter as needed.}*

## ***Treatment Plan***

### **Diagnostic Impression:**

**Axis I** \_\_\_\_\_  
**Axis II** \_\_\_\_\_  
**Axis III** \_\_\_\_\_  
**Axis IV** \_\_\_\_\_  
**Axis V** \_\_\_\_\_

### **Treatment Goals:**

1. Reduce frequency and intensity of:
2. Increase frequency and intensity of:
3. Eliminate:

### **Treatment Methods and Duration:**

\_\_\_\_ Individual sessions  weekly  bi-weekly  monthly

\_\_\_\_ Couple/family sessions  weekly  bi-weekly  monthly

### **Recommendations for Adjunctive Treatment/Assessment:**

### **Plan Review/Revision:**

\_\_\_\_\_  
Lesley Stabinsky Compton, PhD

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date