Lee's Place
216 Lake Ella Drive
Tallahassee, FL 32303

CLIENT INFORMATION FORM FOR CHILD/TEEN (DE)
TO BE COMPLETED BY PARENT/GUARDIAN

Name of child/teen: _____ **Birth Date:** _____ **Age:**_____

Address: _____

street city state zip code

Child/Teen's Phone Numbers: Home:_____ Cell:_____

Current School: _____ **Grades Attended**: _____

Previous School: _____ **Grades Attended**: _____

Extracurricular activities (sports, music, dance, etc): _____

_____

Special education needs: _____

PARENTS/GUARDIAN INFORMATION

Parent's name: _____ **Occupation:** _____

Address (If different from child/teen's): _____

Home Phone: _____**Work Phone:** _____**Cell:**_____

Email: _____

Invoices will be emailed unless requested otherwise

Parent's name: _____ **Occupation:** _____

Address (if different from child/teen's): _____

Home Phone: _____**Work Phone**: _____**Cell:**_____

Email: _____

Emergency contact: _____ **Phone Number:** _____

How did you hear about Lee's Place? _____

Has your child/teen had previous counseling and/or chemical dependency services? None

Facility/Counselor Name	Date(s)	Why Seen?	Helpful?
_____	_____	_____	Y N
_____	_____	_____	Y N

Our fee is based on a sliding scale, please use the attached grid to determine your fee for each session:_____.

Do you have health insurance? ___ Yes ___ No

Does your insurance cover mental health services? ___ Yes ___ No
(*Answering these questions does not commit you in any way to using your insurance.)

Persons Living in Your Home:

Name	Relationship	Age	Special Concern/Problems?

Please answer the following questions about your child/teen so that we may be better able to serve them:

Full name of person who died: _____Age: _____ Date of Death: _____
Relationship of the deceased to the child/teen _____

What other deaths has your child/teen experienced and the approximate dates?
_____
_____

How have the following areas of the child/teen's life been affected since the death?

Relationship with parents/guardians? _____
_____

School/grades/teachers? _____
_____

Friendships/social life? _____
_____

Sleeping/eating habits? _____
_____

Participation in extracurricular activities (e.g. sports, music, dance, etc…)? _____
_____

What concerns did you have about your child/teen before the death? _____
_____
_____
_____

What concerns do you have about your child/teen since the death? _____
_____
_____
_____

Has your child/teen complained of any physical symptoms since the death (stomachache, headache, etc…)?
__ Yes __ No If yes, explain:_____
_____
_____
_____

Please check all that apply to your child/teen.

___ Has an active social life.
___ Has been diagnosed with a mental illness.
___ Is in special classes at school (e.g., gifted, developmentally delayed, honors)
___ Has close friends that he/she can talk to.
___ Has a physical handicap.
___ Has an emotional handicap.
___ Has a mental handicap.
___ Makes friends easily.
___ Is in good health.
___ Is a behavioral problem at home or school.
___ Has a chronic medical condition.
___ Has a supportive family

Of the following emotions, please check all that you think your child/teen is experiencing.

___shock
___ guilt
___ fear
___ anger
___ loneliness
___ hopelessness
___ relief
___ sadness
___ anxiety
___ other: _____
___ embarrassment
___ confusion
___ apathy
___ shame

Please describe any medical problems your child/teen is having. _____
_____
_____
_____

Medications currently taking: _____

What else would you like us to know about your child/teen or your family? _____
_____
_____
_____
_____
_____

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CLIENT AGREEMENT FORM / INFORMED CONSENT

1. I agree to attend my sessions regularly. **I agree to call at least 24 hours in advance when I am unable to attend. I understand that I will be charged for that session without 24 hour notice of cancellation.**

2. I agree to be on time for each session. It is important to those who will be dropping off and picking up a client that they do so at the appropriate times.

3. Parents agree to provide supervision for any children in the waiting area.

4. I agree to pay for each session at the time of service. If I am utilizing insurance, Lee's Place will not bill my insurance directly, but they will be happy to provide me with a receipt for payment.

5. I understand that Lee's Place therapists and staff are only available during regular business hours and that Lee's Place does NOT have 24 hour emergency phone service. Crisis assistance can be obtained by going to the nearest emergency room, calling Telephone Counseling and Referral Service at 211 (or 850.617.6333 if using a cell phone), or by calling 911.

6. The greatest risk of counseling is that it may not by itself resolve my problem or concern. While the staff at Lee's Place will do their best to help me, they may at times, with my consent, team with other medical and mental health professionals to seek the best approach to care.

7. **I have read and understand the statements above. My signature indicates that I give full and informed consent to receive services for myself and/or for my minor child/children.**

Signature of Each Adult Printed Name of Each Adult

_____ _____

_____ _____

Date _____

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CONSENT TO TREATMENT OF A MINOR CHILD

Name: _____ Date of Birth: _____

We, the undersigned, are the legal parents or guardians of the minor child (under the age of 18) referenced above and hereby authorize the therapists at Lee's Place to provide professional services to our child. We understand these services may include individual and family clinical interviews, assessments, consultations, and treatments that the counselors consider to be in the best interest in our child. Services may also include discussions with other providers such as the child's physician, teacher or guidance counselor and communication with individual who have a relationship with our child or other members of our family, such as extended family members, stepparents or close friends.

_____	_____
Print Name	*Print Name*
_____	_____
Signature of Parent/Guardian	*Signature of Parent/Guardian*
_____	_____
Relationship	*Relationship*
_____	_____
_____	_____
Street Address (City, State)	*Street Address (City, State)*
_____	_____
Date	*Date*

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LEE'S PLACE CONFIDENTIALITY POLICY

Our work with you and your family at Lee's Place is confidential. The information you share with the staff, volunteers and other participants is private. Your right to privacy will be strictly maintained. There are, however, some important **exceptions** to confidentiality that are explained below. Please read the seven exceptions to confidentiality before signing this form.

EXCEPTIONS TO CONFIDENTIALITY

1. Florida law requires our staff to report to the appropriate authorities any suspected physical, sexual or emotional abuse or neglect of a child, elderly person or disabled person.
2. If we believe you have a specific intent to harm yourself, we reserve the right to inform other family members and/or make appropriate referrals if necessary, including seeking hospitalization for you.
3. If we believe you intend to harm someone else, we will take steps to protect the intended victim, including contacting law enforcement and informing the intended victim.
4. If information is ordered by the Court, including a subpoena, we will assert to the Court that the information is privileged. Additionally, we will attempt to contact you about the order. If you oppose the release, the Court may require compliance with the order and information would be released.
5. If we come to believe there is drug and/or alcohol use or abuse by a child or a teen, we reserve the right to inform the parent. If we suspect a participating adult is using drugs and/or alcohol before an appointment, we reserve the right to decline further services.
6. These rights and exceptions to confidentiality apply to information disclosed in support groups. All group members are encouraged to keep such information confidential, but Lee's Place cannot guarantee they will do so.
7. At times, Lee's Place uses case examples of children or teens and their families in publishing journal articles, conducting professional training and in fundraising efforts. We may anonymously refer to your situation in those circumstances. However, your names will never be used without specific written approval.

IN SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE LEE'S PLACE CONFIDENTIALITY POLICY. I HAVE READ AND UNDERSTAND THE CONFIDENTIALITY POLICY.

Today's Date _____

Signature of Parents/Legal Guardian _____

Signature of Adult Client_____