

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:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Special Concern/Problems?</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

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

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

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> shock | <input type="checkbox"/> hopelessness | <input type="checkbox"/> embarrassment |
| <input type="checkbox"/> guilt | <input type="checkbox"/> relief | <input type="checkbox"/> confusion |
| <input type="checkbox"/> fear | <input type="checkbox"/> sadness | <input type="checkbox"/> apathy |
| <input type="checkbox"/> anger | <input type="checkbox"/> anxiety | <input type="checkbox"/> shame |
| <input type="checkbox"/> loneliness | <input type="checkbox"/> other: _____ | |

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? _____



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 am responsible for payment of 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 understand that Lee's Place is a nonprofit organization that depends on donations to provide therapy services at reduced fees. I agree that any credits remaining on my account after 3 months of the end of my services at Lee's Place will be considered a donation unless I request in writing for the credit to be returned to me.
8. **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.**

Client Name Printed _____

Signature of Each Adult

Printed Name of Each Adult

Date _____

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 _____



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