



## Please read carefully before proceeding

Lee's Place is a non-profit grief, loss, and trauma counseling center. We are here to provide therapy.

If you want assistance with:

- Lawsuits or other legal issues
- Insurance claims or disputes, including Worker's Compensation
- Child Custody disputes
- Disability claims or applications, including Social Security Disability
- Evaluations or assessments for any of the above
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Please do not proceed.

These services are not offered at Lee's Place



216 Lake Ella Drive  
Tallahassee, FL 32303

## CLIENT INFORMATION FORM (DE)

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ Phone (Cell): \_\_\_\_\_

Email Address: \_\_\_\_\_

Invoices will be emailed unless requested otherwise

Your occupation and employer: \_\_\_\_\_ How Long? \_\_\_\_\_

**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.)

**Relationship status:** Single  Married  Divorced  Widowed  Separated  Partnered   
If married, how long? \_\_\_\_\_ How many times? \_\_\_\_\_ If divorced, how long? \_\_\_\_\_ If separated, how long? \_\_\_\_\_  
If partnered, how long? \_\_\_\_\_

### Spouse/Partner Information:

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

Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ How Long? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

Are you currently involved in or expect to be involved in a lawsuit?  Yes  No

How did you hear about Lee's Place? \_\_\_\_\_

Please answer the following questions so we can better understand your experience:

Name of person who died: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Death: \_\_\_\_\_

His/Her relation to you: \_\_\_\_\_

What other deaths have you experienced and the approximate dates?

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What other changes have you experienced (moved, changed jobs, schools, etc.)?

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**Persons Living in Your Home:**

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Special Concerns/Problems?</u>

**Have you ever been in a relationship where there was (check all that apply):**

- physical violence (slapping, punching, biting, throwing objects, etc.)?
- name calling or put downs?
- controlling or jealous behaviors?
- fear for your own safety or that of your children?
- none of the above

**Please answer the following general health questions so I may better understand your medical history:**

How has your health changed since the loss? \_\_\_\_\_

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Please indicate current health concerns: \_\_\_\_\_

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Please indicate past health concerns: \_\_\_\_\_

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Are you now under the care of a doctor? No Yes If "Yes," state the problem/condition being treated:

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Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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What medications are you currently taking? (please list) \_\_\_\_\_

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Past Hospitalization – Medical, Psychiatric, and/or Chemical Dependency:  None  
Date(s)                      Reason(s)                      Hospital/Facility

Have you ever attempted suicide?     Yes     No

**Please circle the following conditions/problems you are currently experiencing:**

Dizziness/Fainting	Breathing difficulty	Unexplained pain/body aches
Rage	Nausea/Vomiting	Frequent Headaches
Tired most of the time	Irritability	Sleeping too little/ too much
Indigestion/Reflux	Difficulty concentrating	Shaking of hands, arms, or legs
Chills, fever, night sweats	Over/Under eating	Constipation/Diarrhea
Mind racing	Chest tightness	Suicidal Thoughts
Loss of interest in activities	Recent weight change	Jittery/Nervousness
Outbursts of anger	Loss of the will to live	Feeling threatened
Blackouts/Seizures	Violence in the home	Other: _____

## **BEHAVIORS:**

Do you or anyone in your family have addictive behaviors such as gambling, eating, shopping, sex, or excessive computer use? \_\_\_\_\_ yes \_\_\_\_\_ no If yes, please explain each addictive behavior:

Is there, or has there ever been, any substance abuse among any members or your household (ex. Cocaine, alcohol, marijuana, prescription drugs, inhalants, etc.)?      yes      no

If yes, please explain:

Have you had previous counseling and/or chemical dependency services? None

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

**Is there anything else you would like us to know about you or your family?**

**What changes would you like to see as a result of counseling?**



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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 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 (As Guardian)

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Printed Name of Each Adult

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\_\_\_\_\_

## Lee's Place Sliding Fee Scale 2018

Per year Take-Home Income*:	Per month Take-Home Income*:	<u>Per Session Fee based on Number of Dependents:</u>				
		0	1	2	3	4
\$0 - \$20,000	\$0 - \$1,666	\$30	\$30	\$30	\$30	\$30
\$20,001 - \$30,000	\$1,667 - \$2,500	\$45	\$45	\$45	\$40	\$40
\$30,001 - \$40,000	\$2,501 - \$3,333	\$55	\$55	\$55	\$50	\$50
\$40,001 - \$50,000	\$3,334 - \$4,166	\$65	\$65	\$65	\$60	\$60
\$50,001 - \$60,000	\$4,167 - \$5,000	\$75	\$75	\$75	\$70	\$70
\$60,001 - \$75,000	\$5,001 - \$6,270	\$90	\$90	\$90	\$85	\$85
\$75,001 +	\$6,271 +	\$120	\$120	\$120	\$115	\$115

\* Take-Home income is the amount of money your entire household brings home in a year (or month). This includes the income from all working persons in the home, in addition to any child support, alimony, or other sources of regular income.

\*\* Please be prepared to provide a paycheck or W-2 to verify your income.