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

Please do not proceed.
These services are not offered at Lee's Place

Lee's Place Sliding Fee Scale 2020

Find your annual income or your monthly income in the left two columns, then slide right to find the correct number of dependents and you will find your fee.

Annual Take-Home Income*:	**Per month Take-Home Income***:	**Per Session Fee based on Number of Dependents:**				
		0	1	2	3	4
$0 - $20,000	$0 - $1,666	$30	$30	$30	$30	$30
$20,001 - $30,000	$1,667 - $2,500	$40	$40	$40	$30	$30
$30,001 - $40,000	$2,501 - $3,333	$50	$50	$50	$40	$40
$40,001 - $50,000	$3,334 - $4,166	$60	$60	$60	$50	$50
$50,001 - $60,000	$4,167 - $5,000	$70	$70	$70	$60	$60
$60,001 - $75,000	$5,001 - $6,270	$80	$80	$80	$70	$70
$75,001 - $90,000	$6,271 - $7,500	$100	$100	$100	$90	$90
$90, 000 +	$7501 +	$120	$120	$120	$100	$100

*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.

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? (Click in correct box) ☐ 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?

_____

_____

_____

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

_____

_____

_____

_____

Persons Living in Your Home:

Name	Relationship	Age	Special Concerns/Problems?

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? _____

_____

Please indicate current health concerns: _____

_____

Please indicate past health concerns: _____

_____

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

_____

Physicians Name: _____ Phone: _____

What medications are you currently taking? (please list) _____

_____

_____

Past Hospitalization – Medical, Psychiatric, and/or Chemical Dependency: ☐ None

Date(s)	Reason(s)	Hospital/Facility
_____	_____	_____
_____	_____	_____

Have you ever attempted suicide? ☐ Yes ☐ No

Please check each box by all of 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 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.**

By typing my full name on the signature line I confirm that all information is true that I agree to all stipulations as outlined on each page of this form.

Client Name Printed _____

Signature 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.

I further agree that by typing my full name on the signature line below I confirm that all information is true that I agree to all stipulations as outlined on each page of this form.

Today's Date _____

Signature of Parents/Legal Guardian _____

Signature of Adult Client_____

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Telemental Health Informed Consent

I, (print full name) _____, hereby consent to participate in telemental health with,(therapist's name) _____, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I will call you and we will reschedule.
7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

Your therapist needs to know your location in case of an emergency. You agree to inform your therapist of the address where you are at the beginning of each session. We also need a contact person who we may contacted on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

I further agree that by typing my full name in the signature line below that I agree in full to this consent form.

_____ _____
Signature of client/parent/legal guardian Date