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Celebrating 10 Years of Excellence

(1995-2005)

CONSULTATION FORM

Please complete this form so that our Client Liaisons can call you to schedule an appointment. Our Client Liaisons will explain to you the cost and benefits of the consultation and what it includes. You may submit this form by faxing it to us at (954) 382-9997. Alternatively, we invite you to call our Client Liaisons at (954) 382-1997. Please note that **WE DO MAKE HOUSE CALLS** and can schedule a telephone consultation if you are out-of-state or in another area of Florida.

YOUR NAME: _____

YOUR ADDRESS: _____

YOUR PHONE: () _____ - _____

YOUR FAX: () _____ - _____

WHO REFERRED YOU? _____

PERSON FOR WHOM YOU ARE CALLING: _____

RELATIONSHIP TO PERSON FOR WHOM YOU ARE CALLING: _____

ADDRESS OF PARENT/RELATIVE: _____

PHONE NUMBER OF PARENT/RELATIVE: () _____ - _____

MARITAL STATUS: Single _____ Married _____

AGE: _____

VETERAN: (WIDOW/ER OF VETERAN) YES _____ NO _____

TYPE OF MATTER: (Check all that apply)

A. ESTATE PLANNING _____

B. MEDICAID PLANNING _____

C. GUARDIANSHIP _____

D. PROBATE _____

E. PROTECTION of P.I. SETTLEMENT _____

F. TRUST ADMINISTRATION _____

G. OTHER: _____

IS THE PERSON YOU ARE CALLING ABOUT COMPETENT? YES _____ NO _____

IS THE PERSON YOU ARE CALLING ABOUT ILL? YES _____ NO _____

To best prepare for a consultation, please provide the following:

DO YOU OWN: Home _____ Securities _____ Other Assets _____

DO YOU RECEIVE: Social Security _____ Pension _____ Other Income _____

DO YOU HAVE ANY OF THE FOLLOWING LEGAL DOCUMENTS?:

Last Will & Testament _____ Designation of Healthcare Surrogate _____ Living Will _____

Durable Power of Attorney _____ Revocable Living Trust _____

IS THIS AN EMERGENCY? YES _____ NO _____

IS PERSON IN HOSPITAL? YES _____ NO _____ (IF YES, NAME OF HOSPITAL _____)

IS PERSON BEING DISCHARGED FROM HOSPITAL? YES _____ NO _____

ARE ANY OF THE FOLLOWING SITUATIONS APPLICABLE?

A. PERSON DIED AND THERE IS BURIAL PROBLEM _____

B. PERSON IS IN MENTAL HEALTH FACILITY _____

NAME OF FACILITY _____

C. PERSON WAS BAKER ACTED _____

NAME OF FACILITY _____

D. PERSON BEING DISCHARGED FROM NURSING HOME _____

NAME OF FACILITY _____

ADDITIONAL COMMENTS OR CONCERNS: