A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152

Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152

www.apeacefulmind.org

Date_____

Child Intake Form

Child's First Name:	**Middle Name:**
Last Name:	**School & Grade Level:**
Date of Birth: **Age:**	**Child's Preferred Name:**
☐ **Male** ☐ **Female** ☐ **Other** _____	**Address:**
City: **State:**	**Zip Code:**
Child's Phone:	**Preferred Email:**
Emergency Contact Name: **Ph:** **Relationship:**	

Section 2: Parent Information

Parent 1 First Name:	**Last Name:**
Relationship:	**Date of Birth:**
Parent Phone Number:	**Parent 1 Occupation:**
Parent 2 First Name:	**Last Name:**
Relationship:	**Date of Birth:**
Parent Phone Number:	**Parent 2 Occupation:**
Parents Marital Status: ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Other _____	

NOTE: If NOT the biological parents, please provide legal guardianship documents.

How were you referred to our practice? ⬜ Dr's Office: _____ ⬜ Google
⬜ Psychology Today ⬜ Referral _____ ⬜ Other _____

Section 3: Child Intake Information

1. What grade is your child in? _____ What school? _____

2. Are there any education/developmental concerns that we should know about? ⬜ Yes ⬜ No

(*If yes, please explain*) _____.

3. Is there any current legal involvement? ⬜ Yes (specify) ⬜ No (if no, skip to question 5).

Date of arrest: _____ Agency Arresting: _____
Charges: _____ Status of case: _____
Attorney: _____ Ph: _____
Would you like us involved in helping you with your case? ⬜ Yes ⬜ No

4. Do you have any current Department of Children and Families (DCF) involvement? ⬜ Yes ⬜ No

(If yes, would you like us involved in helping you with your case? ⬜ Yes ⬜ No

(*If yes, please explain*) _____.

5. Is your child currently experiencing any of the following?

⬜ **Sudden confusion** ⬜ **Vomiting** ⬜ **Using laxatives to lose weight** ⬜ **Sudden memory loss**
⬜ **Current hallucinations** ⬜ **Severe restriction of calories** ⬜ **Sudden disorientation** ⬜ **Hearing voices**

6. Is your child currently taking any medications? ⬜ Yes ⬜ No (If no, skip to question 8).

Medication _____ Dose/Frequency _____ Dr. _____

Reason: _____ Started _____

Medication _____ Dose/Frequency _____ Dr. _____

Reason: _____ Started _____

Medication _____ Dose/Frequency _____ Dr. _____

Reason: _____ Started _____

Medication _____ Dose/Frequency _____ Dr. _____

Reason: _____ Started _____

7. Any family history of substance abuse or addiction? ⬜ Yes ⬜ No *If yes, please explain:*

_____

8. Would you or someone you know say that your child is having a problem with alcohol? ⬜ Yes ⬜ No
9. Would you or someone you know say that your child is having a problem with illegal drugs? ⬜ Yes ⬜ No
10. Would you or someone you know say that your child is having a problem with any other addiction? ⬜ Yes ⬜ No

NOTE to Parent: We offer lab based drug screenings collected in our office. The results are completely confidential and are only shared between you, your therapist and your child. This could be useful to determine the proper level of care for your child. Please notify your therapist if you would like to have your child tested now or during the course of their care.

11. Are you currently (or in the last 30 days) experiencing any of the following symptoms? (check all that apply)

☐ Sadness	☐ Hopeless/Helpless	☐ Sleep Too Much	☐ Fatigue/No Energy	☐ Poor Memory
☐ No Motivation	☐ Lack of Interest	☐ Thoughts of Dying	☐ Guilt	☐ Feel Worthless
☐ Not Hungry	☐ Prefer Being Alone	☐ Irritable/Angry	☐ Can't Sleep	☐ Too Much Energy
☐ No Need for Sleep	☐ Talk Too Fast	☐ Impulsive	☐ Can't Concentrate	☐ Restless/Can't Sit Still
☐ Suspicious	☐ Hearing Things	☐ Seeing Things	☐ Have Special Powers	☐ People Watching Me
☐ People Out to Get Me	☐ Feeling Nervous	☐ Fearful	☐ Panic Attacks	☐ Can't be in Crowds
☐ Easily Startled	☐ Avoidance	☐ Re-occurring Nightmares		

12. Child currently employed? ☐ Yes ☐ No (*If yes, type of work)* _____

13. Any spiritual or religious beliefs/orientation? _____

14. Any family history that we should know about? _____

_____

_____

15. Ever been in counseling or treatment before? ☐ Yes ☐ No *(If yes, please explain as much as you feel comfortable)* _____

_____

_____

16. What are you experiencing at this time that motivated you to seek help? _____

_____

_____

_____

_____

For Office Use Only

☐ ADMIN FORM 02 Completed Intake Form ☐ ADMIN FORM-03 HIPAA Acknowledgment

☐ ADMIN FORM-04 Informed Consent ☐ ADMIN FORM-05 Telephone Use Agreement

☐ ADMIN FORM-06 Financial Agreement ☐ ADMIN FORM-07 ROI's ☐ Copy of Identification

A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152
Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152
www.apeacefulmind.org

Health Insurance Portability and Accountability Act- HIPAA Acknowledgement
Client Consent for Use and Disclosure

I hereby give my consent for A Peaceful Mind Counseling Group, LLC to use and disclose protected health information (PHI) about me, and/or my child, for the purposes of carrying out treatment, payment and health care operations. (The Notice of Privacy Practices provided by A Peaceful Mind Counseling Group describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. A Peaceful Mind Counseling Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by contacting our office. It should be noted, that while you have the right to refuse to sign this form, **certain disclosures may still be required as defined by state, local or federal law**.

With this consent, A Peaceful Mind Counseling Group, LLC and its representatives may call my home or other alternative location and leave a message on voicemail or in person regarding any items that assist the practice in carrying out services, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, A Peaceful Mind Counseling Group, LLC and its representatives may mail to my home or other alternative location, any items that assist the practice in carrying out services, such as appointment reminder cards and patient statements a s long as they are marked "Personal and Confidential."

With this consent, A Peaceful Mind Counseling Group, LLC and its representatives may e‑mail to me or other alternative email address, any items that assist the practice in carrying out services, such as appointment reminder cards and patient statements. I have the right to request that A Peaceful Mind Counseling Group, LLC restrict how it uses or discloses my PHI to carry out services. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent for A Peaceful Mind Counseling Group, LLC to use and disclose my Personal History Information and/or that of my child, in the manners listed above and as deemed necessary by law or to carry out any services to include payment and payment collection. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, A Peaceful Mind Counseling Group, LLC may decline to provide treatment to me. I also agree that I have been provided with a copy of my privacy rights.

_____	_____	_____
Parent Print Name	Signature	Date

☐ Check here if Minor with NO signature

_____	_____	_____
Child Print Name	Signature	Date

A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152

Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152

www.apeacefulmind.org

Child/Minor Informed Consent

I, _____, parent/legal guardian of _____
(parents name) *(child's name)*
voluntarily give consent to A Peaceful Mind Counseling Group, LLC. for the purposes of psychological/counseling services to include collection of urine drug screens on site.

These services may include but are not limited to: psychological assessment or evaluation, counseling, consultation, parent training, Eye Movement Desensitization and Reprocessing (EMDR), or any other practice as allowed by law. Furthermore, I understand that as a mandated reporter, certain events or situations may be reported as required by law. I understand that counseling services are confidential except for the following scenarios:

- Knowledge or reasonable suspicion of harm to self or others
- knowledge or reasonable suspicion of child or elder abuse, and
- court order for information regarding your case.
- As otherwise required by local, state or federal law.

Psychological services are intended to be beneficial in the improvement of mental health or academic concerns however, none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of services. Alternative referrals to another health care provider will be given if desired.

A Peaceful Mind Counseling Group provides only outpatient mental health and substance abuse services and does not guarantee emergency intervention, particularly if it is necessary after business hours. If you require emergency services, please call 911 or your local crisis center.

Eye Movement Desensitization and Reprocessing (EMDR): I affirm that I have never been diagnosed with Dissociative Identity Disorder or that I will inform my therapist if I have. I will inform my therapist if I am epileptic, suffer from seizures, have had or will have eye surgery, macular degeneration or any other eye or neurological conditions.

Student/Intern: A Peaceful Mind Counseling Group is committed to the development of the mental health counseling field. As such, we are a student placement site for interns and students currently in graduate studies of a psychology/counseling degree program. A Peaceful Mind Counseling Group may determine that a student/intern may be most appropriate to work with you or your family member or may be present during a therapy session for clinical observation as part of their education. If you wish not to work with an intern, you reserve the right to refuse a student placement by notifying your therapist or the administration.

By signing below, I confirm that I have read this form in its entirety or it was read/explained to me, and I understood the information included in it. I have no additional questions and I have clarified any information with which I disagree. I further understand that my consent is voluntary and can be revoked at any time.

_____	_____	_____
Client Name	Signature	Date

☐ Check here if minor with no signature

_____	_____	_____
Parent/Guardian Name	Signature	Date

A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152
Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152
www.apeacefulmind.org

CHILD/MINOR Telephone/Electronic Use Agreement

Thank you for choosing A Peaceful Mind Counseling Group to work with you and/or your family. It is important for the sake of your confidentiality that we understand the responsibilities associated with use of mobile phones.

At a Peaceful Mind, we take your confidentiality very seriously. We have systems in place to uphold the highest standards of protection for your files and your personal health information (PHI). Due to the use of technology and its advancements, there may be times where you will utilize my email or my phone number for sending information. Please take note of the following:

a) Do not send confidential information via email without using an encryption service. For documents that you feel our practice should have, either bring them with you or fax them to the number listed above.

b) Do not use my mobile number, email (or any other electronic method) for discussing confidential or treatment related information. This includes, but is not limited to, text messages, pictures, videos, or any other form of media sharing platform. The use of text messages can be for booking or cancelling appointments or communicating basic information however, I will not respond to any clinical questions or discussions via text, email or other media outlet. This is to protect you in the event that your information is accessed by unauthorized people.

c) In the event of a crisis or emergency, please call 911 or go to your nearest emergency room. A Peaceful Mind Counseling Group does not provide after-hours crisis support and you may not be able to reach a counselor until the next business day.

d) We encourage you to assign my phone number into your mobile device with the name that you feel is suitable. While I will never identify my profession or the reason for my call to someone that is not authorized to know about this service, I will ask for you and give my personal name if I call you.

Please check the option you are most comfortable with regarding messages and sign below.

☐ Okay to leave voicemail/email/text message ☐ Do **NOT** leave voicemail/email/text message

By signing below, you agree that you have read, understand and will adhere to the telephone/electronic use agreement.

Parent Print Name	Signature	Date

☐ Check here if Minor with NO signature

Child Print Name	Signature	Date

A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152

Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152

MINOR Telehealth Consent Form

I _____ hereby consent to engage in telehealth (internet and/or phone based therapy) with A Peaceful Mind Counseling Group, LLC as an alternate mode to my therapy services. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine may also involve the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to my confidentiality which are intended to keep me and others safe. Details on these limitations were read, explained and agreed to when I completed the Informed Consent and the HIPAA acknowledgement form.

(3) I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information forms could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner. In addition, I understand that telehealth-based services may not yield the same results nor be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy to include telehealth.

(4) I understand that I may benefit from telehealth, but results cannot be guaranteed or assured. The benefits of telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that while my therapist will make every effort to protect my information, he/she cannot protect all information on my end. Therefore, I will make sure that I am always in a safe, private and secure area when I begin any telehealth session and for the duration of that meeting. I will also be ready for my session at the agreed upon appointment time, in a safe/secure location and dressed appropriately for said session. I understand that headsets are encouraged to protect information discussed between my therapist and I.

(6) Because appointments are reserved specifically for you, other clients are often waiting weeks for an appointment with their therapist. I understand that the cancelation policy for telehealth applies just as agreed to on the Financial Responsibility & Guarantee of Payment form, which explains among others, that we require 48 hours advance notice for cancellations or I will be charged up to the standard rate amount for no show or late cancel (up to $250).

(7) I understand that these services may not be covered by insurance. I have read and understand this information or it has been explained to me verbally. I have discussed it with my therapist and all of my questions have been answered to my satisfaction.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Signature	Date

A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152
Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152
www.apeacefulmind.org

CHILD/MINOR Financial Responsibility and Guarantee of Payment

Thank you for choosing A Peaceful Mind Counseling Group to work with you and/or your family. I take great pride in having the opportunity to work with you and will value your time as if it were my own. Because appointments are specifically booked and held for you, other clients that would need this time are turned away out of respect for our session. Therefore, I require **48-hours advance notice** if you intend to cancel.

If we do not receive notification within that time frame, we will charge you **up to** our standard rate for the late cancellation/no show. The practice will retain a copy of your current payment method in the electronic database which is secure, confidential and Health Insurance Portability and Accountability Act (HIPAA) compliant. This method of payment will be charged for the hourly rate in the event that a cancellation notice is not received.

If you would like to have a different credit card on file, please provide the credit card information below. We accept all major forms of payment.

Name on card: _____ Expiration Date:_____/_____ Billing Zip Code: _____

Credit Card #_____-_____-_____-_____ 3 Digit Security Code: _____

For returned checks, credit/debit card declines or chargebacks by your bank, you are expected to pay any associated bank fees **and** the full charge for those services within 3 business days. Returned checks will also result in no further checks being accepted for future services.

Insurance Disclaimer: While we do make every effort to assist in providing you with documentation needed for insurance purposes including (when possible) billing directly to your insurance, it is ultimately your responsibility to understand your insurance plan and whether or not they provide in or out of network benefits. Any issues with reimbursement are the responsibility of the client and the insurance company, not A Peaceful Mind Counseling Group. Because of the inconsistency with health insurance, they may at any time deny payment for services that were already rendered to you. Therefore, A Peaceful Mind Counseling Group reserves the right to charge you for any services that were not covered by your insurance.

By signing below, you agree that you understand the cancellation policy and you authorize A Peaceful Mind Counseling Group to charge your card for any balance to include that resulting from no show visits, late cancellations and/or insurance non-payment.

_____	_____	_____
Child Name	Signature	Date

☐ Check here if minor with no signature

_____	_____	_____
Parent/Guardian Name	Signature	Date

A Peaceful Mind® Counseling Group

Fort Myers
12381 South Cleveland Ave ✦ Suite 401 ✦ Fort Myers, FL 33907
Ph: 239-266-2620 ✦ Fax: 239-842-1152

Fort Lauderdale
Ph: 954-595-9100 ✦ Fax: 239-842-1152

www.apeacefulmind.org

Notice of Privacy Practice

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Our Legal Duties State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records. Use of Information Information about you may be used by the personnel associated with A PEACEFUL MIND COUNSELING GROUP, LLC. for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with A PEACEFUL MIND COUNSELING GROUP, LLC. such as billing, quality enhancement, training, audits, and accreditation. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of A Peaceful Mind Counseling Group, LLC. not to release any A PEACEFUL MIND COUNSELING GROUP, LLC information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person or persons, the healthcare professional is required to warn the intended victim and report this information to legal authorities. In cases where the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. Public Safety Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse: If a client states or suggests that he or she 1) is abusing a child or vulnerable adult, or 2) has recently abused a child or disabled adult, or a disabled child or adult 3) is in danger of abuse, the healthcare professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator. **Prenatal Exposure to Controlled Substances:** Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. **In the Event of a Client's Death:** In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. **Professional Misconduct:** Professional misconduct by a healthcare professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the healthcare professional's actions, related records may be released in order to substantiate disciplinary concerns. **Judicial or Administrative Proceedings:** Healthcare professionals are required to release records of clients when a court order has been placed. **Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions: When payment for services are the responsibility of the client, or a person who has agreed to provide payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The

specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time frame, and the name of A Peaceful Mind Counseling Group, LLC. or collection source. Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within A Peaceful Mind Counseling Group, LLC. by outside sources specializing in (and held accountable for) such procedures. A Peaceful Mind Counseling Group, LLC. or the mental health professional may telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information. Efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of A Peaceful Mind Counseling Group, LLC. the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us in writing, we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of A Peaceful Mind Counseling Group, LLC. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify A Peaceful Mind Counseling Group, LLC (to protect confidentiality). If we reach an answering machine or voicemail, we will follow the same guidelines. **Your Rights** You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows: You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is up to $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice and signing the revocation section of the original release. If you desire to have your information sent to a location different than your address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in

writing. You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom and you must request this in writing. If you desire a written copy of this notice you may obtain it by requesting it from A Peaceful Mind Counseling Group, LLC staff.

Complaints/Concerns: If you have any concerns or questions regarding these procedures, please contact the director of A Peaceful Mind Counseling Group, LLC. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the (therapist's state licensing agency). You have the right to report any complaints without fear of retaliation in any way.

IMPORTANT CRISIS NUMBERS

If you require emergency services, please call 911 or your local crisis center.

- Broward County: Henderson Behavioral Health 954-739-8066
- Collier County: David Lawrence Center 239-455-8500
- Charlotte County: Charlotte Behavioral Health 941-575-0222
- Lee County: Salus Care (239) 275‑4242
- 24-hour Suicide Prevention line 1-800-273-8255