RONALD W. NELSON, PA

7501 COLLEGE BOULEVARD, SUITE 105
OVERLAND PARK, KS 66210-2776

TEL: 913.312.2500
FAX: 913.312.2501

For Office Use: File No. ________________________ Date of Initial Meeting __________________________ _

LIMITED-SCOPE REPRESENTATION INITIAL CONSULTATION

This agreement is made this ___ day of ________, 20____, between ________________________ and the Law Offices of Ronald W. Nelson, P.A., "Attorneys" for a one-time consultation. I understand that Ronald W. Nelson, P.A. is providing this one-time consultation for the purpose of evaluating the following identified issues and providing legal advice for these issues. I understand that unless I execute the following

(1) Make full-payment of any required fee or retainer to Ronald W Nelson, PA, and
(2) Sign an Attorney-Client Agreement with Ronald W Nelson, PA.

Attorneys do not represent me in a continuing manner and that upon completion of this meeting, Attorneys do not have any continuing responsibilities as my representative. Unless I enter into a separate Attorney-Client Agreement, Ronald W. Nelson, P.A. does not represent me in any court actions and will not respond to any contacts made by persons adverse to me.

____
Potential Client Signature

YOUR INFORMATION

Name: ________________________ Birth date: __________ SSN: ________________

Current address: ____

What is the date you moved into your current address? ________________________

If less than 6 months at your current address, please list previous address(es) for the past 6 months:

____

Main phone no.: ________________ *(circle one)* **CELL HOME WORK OTHER** Secure line? **YES NO**

Alternate phone: ________________*(circle one)* **CELL HOME WORK OTHER** Secure line? **YES NO**

E-Mail: ______________________________ Do you use any Social Networking Site? **YES NO**

Social Network Sites Used:____

Current employer: ____________________Current position: ____________________

Employer address: ____

Emergency contact name: ________________________ Relationship: ________________

Emergency contact's Phone no.: __________ *(circle one)* **CELL HOME WORK OTHER** Secure line? **YES NO**

Your Case no.: ________________ **County, state:** ________________________

How were you referred to our office? ________________________________

OTHER PARTY INFORMATION

Name: ________________________ Birth date: __________ SSN: ________________

Current address: ____

How long at this address? ____

If less than 6 months at current address, list previous address:

____

Represented by (Attorney): ________________ Current employer: ________________

Current position: ________________ Employer address: ________________________

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RELATIONSHIP INFORMATION

Marriage: **YES NO** Marriage Date: ______________ Marriage Place *(County/State)*: ________________________

Date First Lived Together: ___________ Separation Date: ___________ Date of Divorce *(if applicable)*:_________

Your Previous Marriage: Date of Marriage _________ Date of Divorce_______ Number of Children? _________
County/State of Divorce: ____

Your Previous Marriage: Date of Marriage _________ Date of Divorce_______ Number of Children? _________
County/State of Divorce: ____

Your Previous Marriage: Date of Marriage _________ Date of Divorce_______ Number of Children? _________
County/State of Divorce: ____

Your Spouse/Partner's Previous Marriage: Date of Marriage ______________ Date of Divorce _______________
Number of Children? ______ County/State of Divorce: ____

Your Spouse/Partner's Previous Marriage: Date of Marriage ______________ Date of Divorce _______________
Number of Children? ______ County/State of Divorce: ____

Your Spouse/Partner's Previous Marriage: Date of Marriage ______________ Date of Divorce _______________
Number of Children? ______ County/State of Divorce: ____

COUNSELING

Have you or your spouse received counseling or otherwise consulted with a counselor, psychologist, social worker, or psychiatrist? **YES NO** If yes, who was treated? ____

What type of treatment? ______________________________________ Date(s) of treatment: ___________________

Name of counselor: ____ Permission to contact? **YES NO**

Phone: _____________________ Address: ____

CHILDREN'S INFORMATION

Have you and your spouse/partner discussed the living arrangements for the child/ren following divorce (or separation)? **YES NO** Outcome of discussion: ____

Current parenting time schedule: ____

____

Preferred parenting time schedule: ____

____

Do your children require work-related child-care? **YES NO** If yes, monthly cost: ___________________________

Who provides health insurance coverage of the child/ren? ____

Premium Amount: FAMILY: ______________ CHILD/REN ONLY: _____________

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1st Child's Name: ______________________ SSN: ______________________
Birth date & age: ______________________ Is this a child of this marriage? **YES** **NO**
Where is the child living now? ______________________
Describe child's special needs, if any: ______________________

2nd Child's Name: ______________________ SSN: ______________________
Birth date & age: ______________________ Is this a child of this marriage? **YES** **NO**
Where is the child living now? ______________________
Describe child's special needs, if any: ______________________

3rd Child's Name: ______________________ SSN: ______________________
Birth date & age: ______________________ Is this a child of this marriage? **YES** **NO**
Where is the child living now? ______________________
Describe child's special needs, if any: ______________________

Additional children?) **YES** **NO** *PLEASE CONTINUE WITH ADDITIONAL CHILDREN AT THE END OF THIS FORM.*

Who claims the child/ren as dependents on tax return: FATHER ______________ MOTHER ______________
Who itemizes deductions on the tax return? FATHER ______________ MOTHER ______________
Filing status: *(circle one)* **JOINT** **MARRIED-FILING-SEPARATELY** **HEAD-OF-HOUSEHOLD** **SINGLE**

FERTILITY HISTORY AND INFORMATION

Do you or your spouse have any stored genetic material? **YES** **NO**
If so, state what type of genetic material is stored and whose it is: ______________________
Name and address of storage facility: ______________________
What is your intended use or other disposition of all stored genetic material at this time?
____

Are any of your children born as the result of fertility treatments **and** not genetically related to both you and your spouse? **YES** **NO** If yes, their names: ______________________
Name and address of fertility clinic from which you obtained the third-party genetic material:
____

Did you execute any documents in connection with the contribution? **YES** **NO**
Have you completed any legal proceedings to establish the parentage of the children resulting from your fertility treatments? **YES** **NO**

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WHAT WOULD YOU LIKE TO ACCOMPLISH WITH YOUR INTIAL VISIT?

____

Additional Children *(use back of sheet if needed)*: