[LAW FIRM NAME]

[Street Address] • [City, State ZIP] • [Phone] • [Email]

CLIENT INTAKE QUESTIONNAIRE

Young Adult Planning Package: Health Care Power of Attorney • Financial (Durable) Power of Attorney • HIPAA Authorization • Education Records (FERPA) Release

PLEASE NOTE: This is an intake form and NOT an actual legal document. Completing this document requires an additional step in contacting an estate planning attorney to draft the relevant powers of attorney and other directives.

Purpose: Once a person turns 18, parents and guardians no longer have automatic legal authority to make medical or financial decisions for them, receive their medical information, or access their school records. When an individual turns 18 years of age, they are an adult in the eyes of the law. Therefore, an adult individual, even one that is still a full-time student, has certain rights to privacy. For this reason consent is necessary to allow access to information including but not limited to: health care, financial and educational records. This questionnaire gathers the information needed to prepare documents that let the young adult voluntarily grant those rights to a parent, guardian, or other trusted person. All information is confidential and protected by attorney-client privilege. Please complete as fully as possible; leave blank anything you are unsure about and we will review it together.

SECTION 1 — CLIENT INFORMATION (Young Adult / Student)

The "Client" is the young adult (age 18 or older) who will sign the documents. He or she is our client, and the documents must reflect his or her own voluntary choices.

Full legal name:

Preferred name / nickname: Date of birth:

Phone (cell): Email:

Permanent home address:

School / campus address (if different):

U.S. citizen? ☐ Yes ☐ No — country: Marital status:

State of residence / domicile: State where attending school:

If the Client lives or studies in more than one state, we may recommend executing documents and providing to each educational institution. Any legally enforceable document in Tennessee should be enforceable in another state pursuant to the full faith and credit clause of the U.S. Constitution. See U.S. Const. art. IV, § 1.

SECTION 2 — SCHOOL / EDUCATION INFORMATION

Name of school, college, or university:

Nancy A. Cogar, Attorney at Law, Samples Jennings PLLC/BoomerTime™ LLC 130 Jordan Drive, Chattanooga, TN 37421 Office: (423) 892-2006 Direct: (423) 596-7220

Email: ncogar@sampleslaw.com or nancycogar.attorney@gmail.com

Student ID number: Expected graduation year:

Registrar / records office contact (if known):

School health center / counseling center (if known):

Should we also complete the school's own FERPA / proxy-access form, if it has one? ☐ Yes ☐ No

Does the client live in on-campus housing? ☐ Yes ☐ No

SECTION 3 — PARENT(S) / GUARDIAN(S) TO BE NAMED AS AGENT(S)

An "agent" (also called an "attorney-in-fact") is the person the client authorizes to act on his or her behalf. Most clients name a parent or guardian as primary agent and a second person as successor (backup) agent. The same or different people may be named for health care and financial matters.

Primary Agent

Full legal name:

Relationship to client: Date of birth:

Home address:

Phone (cell): Alternate phone:

Email:

Appoint this person as agent for:

- ☐ Health care decisions
- ☐ Financial matters
- ☐ Both

Successor (Backup) Agent

Full legal name:

Relationship to client: Date of birth:

Home address:

Phone (cell): Email:

Appoint this person as successor agent for:

- ☐ Health care decisions
- ☐ Financial matters
- ☐ Both

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If Two Parents/Guardians Are Named Together

☐ They may act independently (either one can act alone) — most common

☐ They must act jointly (both must agree)

☐ Not applicable — only one agent at a time

SECTION 4 — HEALTH CARE POWER OF ATTORNEY

This document lets the named agent make medical decisions for the client if the client cannot make or communicate them (for example, after an accident or during a serious illness). It can also authorize the agent to speak with doctors and receive medical information even when the client is able to decide for himself or herself.

4.1 When the Agent May Act

☐ Only if a physician determines the client cannot make or communicate health care decisions (standard)

☐ Immediately upon signing, so the agent can also assist and communicate with providers while the client has capacity

4.2 Scope of Health Care Authority — check any the client wishes to EXCLUDE or LIMIT

Unless limited below, the agent will generally have full authority to consent to, refuse, or withdraw any medical treatment, choose providers and facilities, and access medical records.

☐ Mental / behavioral health treatment decisions

☐ Admission to a mental health facility

☐ Reproductive health decisions

☐ Organ / tissue donation decisions

☐ Other limitation (describe):

☐ No limitations — full authority

4.3 End-of-Life Preferences (optional — may be addressed in a separate living will / advance directive)

Does the client also want a living will / advance directive prepared? ☐ Yes ☐ No

Should the agent have authority to make decisions about life-sustaining treatment? ☐ Yes ☐ No

Any specific wishes, religious considerations, or instructions:

4.4 Medical Background (helps the agent and providers in an emergency)

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Primary care physician — name / phone:

Known allergies (medications, food, other):

Current medications:

Significant medical conditions or history:

Health insurance carrier: Policy / member number:
Preferred hospital (if any):

SECTION 5 — HIPAA AUTHORIZATION (Release of Medical Information)

Federal privacy law (HIPAA) prevents doctors, hospitals, campus health centers, and insurers from sharing an adult's medical information — even with parents — without written authorization. A standalone HIPAA authorization lets the people named below receive information and updates at ANY time, even when the health care power of attorney has not been triggered.

Persons authorized to receive the client's protected health information:

1. Name / relationship:
2. Name / relationship:
3. Name / relationship:

Categories of information to release (check all that apply):

- ☐ All medical records and information (most common)
- ☐ EXCLUDE mental / behavioral health and psychotherapy notes
- ☐ EXCLUDE substance-use treatment records
- ☐ EXCLUDE reproductive / sexual health records
- ☐ EXCLUDE HIV/AIDS-related records
- ☐ Other exclusion:

Duration of authorization:

- ☐ Until revoked in writing by the client (most common)
- ☐ Expires on date or event:

SECTION 6 — FINANCIAL (DURABLE) POWER OF ATTORNEY

This document lets the agent handle financial and legal matters for the client — for example, banking, paying tuition and rent, dealing with the landlord, filing taxes, or managing accounts if the client is abroad, hospitalized, or otherwise unavailable. "Durable" means it remains effective even if the client becomes incapacitated.

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6.1 When the Financial Agent May Act

☐ Immediately upon signing (agent can act at any time; most flexible for students)

☐ Only upon the client's incapacity, certified by a physician ("springing" — takes effect only in an emergency)

6.2 Powers Granted — check all the client wishes to grant

☐ Banking: deposits, withdrawals, transfers, opening/closing accounts

☐ Paying bills, tuition, housing, and other expenses

☐ Dealing with the school's bursar / student accounts / financial aid office

☐ Managing scholarships, grants, and student loans

☐ Signing, renewing, or terminating leases and housing agreements

☐ Managing investments and retirement accounts

☐ Filing and signing tax returns; dealing with tax authorities

☐ Insurance matters (health, auto, renter's)

☐ Vehicle-related transactions (registration, sale, repair)

☐ Government benefits and claims

☐ Digital assets and online accounts

☐ Legal claims and litigation

☐ ALL of the above — general grant of authority

☐ Exclusions or special limits:

6.3 Optional Protections

May the agent make gifts of the client's property? (If yes, we will discuss limits.) ☐ Yes ☐ No

Should the agent be required to keep records / provide an account on request? ☐ Yes ☐ No

Should compensation for the agent be allowed? (Most family agents serve without pay.) ☐ Yes ☐ No

6.4 Financial Snapshot (brief — helps us tailor the document)

Bank(s) / credit union(s) where client holds accounts:

Investment, brokerage, or custodial (UTMA/529) accounts, if any:

Does the client have a vehicle? ☐ Yes ☐ No: Employed? ☐ Yes ☐ No:

Student loans / financial aid (lender or program):

SECTION 7 — EDUCATION RECORDS RELEASE (FERPA CONSENT)

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Under the Family Educational Rights and Privacy Act (FERPA), once a student is 18 or enrolls in college, the school generally may not share grades, transcripts, disciplinary records, health records, or financial account information with parents without the student's written consent. This release lets the persons named below request and receive the client's education records from the school at any time.

Persons authorized to receive education records:

1. Name / relationship:
2. Name / relationship:

Records to be released (check all that apply):

- ☐ ALL education records (most common)
- ☐ Grades, transcripts, and academic progress
- ☐ Enrollment, registration, and attendance
- ☐ Tuition, billing, and financial aid records
- ☐ Disciplinary and conduct records
- ☐ Campus housing records
- ☐ Campus health / counseling records (to the extent held as education records)
- ☐ Exclusions:

Duration:

- ☐ Until revoked in writing by the client
- ☐ While enrolled at the school named in Section 2
- ☐ Other:

Should the agents also be authorized to communicate with school officials (deans, advisors, housing, study-abroad office) on the client's behalf? ☐ Yes ☐ No

SECTION 8 — EMERGENCY CONTACTS & ADDITIONAL INFORMATION

Emergency contact #1 — name / relationship / phone:

Emergency contact #2 — name / relationship / phone:

Is the client planning to study abroad or travel internationally in the next two years? ☐ Yes ☐ No

Does the client have any existing power of attorney, advance directive, or will? ☐ Yes ☐ No

Anything else we should know (family circumstances, concerns, special instructions):

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SECTION 9 — CLIENT ACKNOWLEDGMENT & CONSENT

By signing below, I acknowledge and agree that:

1. I am at least 18 years old, and I am the client. I understand the attorney represents me — not my parents or guardians — and that the documents will reflect my own voluntary decisions.

2. I am asking the firm to prepare a Health Care Power of Attorney, a Financial (Durable) Power of Attorney, a HIPAA Authorization, and an Education Records (FERPA) Release naming the person(s) I have identified in this questionnaire.

3. I consent to the person(s) named in this questionnaire acting as my agent / attorney-in-fact in the circumstances I have selected, including in cases of emergency, and receiving my otherwise-private medical, financial, and education information as I have indicated.

4. I understand that I may limit, change, or revoke these documents at any time while I have capacity, and that no document is effective until it is properly signed, witnessed, and/or notarized as required by state law.

5. The information I have provided is true and complete to the best of my knowledge.

_____ _____

Client signature Date

_____ _____

Client printed name

Optional — Parent/Guardian Acknowledgment:

I have reviewed this questionnaire. I understand that the client is the attorney's sole client, that the documents reflect the client's wishes, and that I am willing to serve as agent if named.

_____ _____

Parent/Guardian signature Date

_____ _____

Parent/Guardian signature Date

FOR OFFICE USE ONLY

Date received: Attorney:

Matter no.: Conflicts check completed ☐:

Engagement letter signed ☐: State-law forms verified ☐:

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This questionnaire is for information-gathering only. It is not a power of attorney, does not create any legal authority, and does not by itself create an attorney-client relationship. Execution requirements (witnesses, notarization, and statutory forms) vary by state.

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