1

NOTICE OF PRIVACY & STATEMENT OF UNDERSTANDING

To be signed by EAP client prior to receiving services.

NOTICE OF PRIVACY

The federal laws that protect your health information are the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Confidentiality Law, 42 U.S. Code 290dd-3 and CFR part 2. Under these laws, EAP Works may not inform others that you attend EAP counseling or disclose any other protected information except as permitted by your signature or federal and state laws, or pursuant to an agreement with a qualified service organization/business associate. If you wish to make a complaint, you are encouraged to contact the director of EAP Works or Secretary of the United States Department of Health and Human Services. Under HIPAA you have the right to inspect and copy the health information maintained at EAP Works except to the extent that the information contains counseling notes or information compiled for use in civil, criminal, or administrative proceedings or in other limited circumstances. You also have the right, with some exceptions, to amend health care information. EAP Duties: EAP Works is required by law to maintain the privacy of your health information and to provide you with this notice of its legal duties and privacy with respect to your health information.

STATEMENT OF UNDERSTANDING

EAP Works provides the following services: an assessment, short-term (non-medical) counseling services, and referrals for personal and job-related concerns. Follow-up services may also be provided. These services are provided at no cost to eligible employees and dependents. If your EAP counselor refers you beyond the EAP to a clinician or facility for your special needs, we attempt to refer you "in-network" with regards to your insurance coverage. However, please be advised that you are responsible for any payment beyond the EAP services, and you are also responsible for contacting your benefits plan for preauthorization if necessary. Please call your EAP counselor to cancel any scheduled appointments 24 hours in advance if you are not able to attend. Except in cases of an emergency, the appointment will be counted as one of your EAP sessions. By signing this document, you allow your EAP counselor to be paid by EAP Works.

Confidentiality: The EAP will maintain confidential records of any contact with the EAP and the services provided to you in order to coordinate your care and pay EAP Affiliate Counselors. No one will reveal information concerning your use of the EAP to anyone outside the program except in the following circumstances: 1) Your consent in writing, such as the EAP counselor speaking with your physician or employer; 2) Safety, such as if you threaten to harm yourself or others in ways such as suicide, child abuse, spouse abuse, or threats of violence toward fellow employees; 3) When there is a valid court order; 4) When your counselor refers you to benefits-covered treatment, and the claim pays or requires information; 5) When a crime is committed by a client at the EAP, or against any person who works for the EAP; and 6) For research, audit, or evaluations.

DISCLOSURES OF INFORMATION: Under federal and state regulations, certain disclosures of information may be made: 1) When the client consent is in writing; any such written consent may be revoked by you in writing; 2) Pursuant to an agreement with a qualified service organization/business associate; 3) To other mental health practitioners who are involved in providing your mental health care, as long as information does not pertain to substance abuse; 4) When the disclosure is allowed by a valid court order; 5) When the disclosure is made to medical personnel in a medical emergency or when the disclosure is made in a non-identifiable form to qualified personnel for research, audit, or program evaluation; 6) If there is a situation where the safety of the public or an individual is concerned, EAP Works may be required to notify the intended victim and/or law enforcement officials; 7) When there is suspected child or elder abuse or neglect; 8) When a crime is committed by a client at EAP Works, or against any person who works for EAP Works, or when there is a threat to commit such a crime; and 9) For research, audit, or evaluations. Other disclosures may be made without your written consent as follows: 1) If an EAP client is committing a crime against his/her employer, EAP Works reserves the right to disclose that information to the client's employer; and 2) To a private firm, individual, or group (EAP Affiliate) providing EAP functions contractually with EAP Works.

EAP CLIENT SIGNATURE IS REQUIRED TO RECEIVE SERVICES

By signing, I affirm that I understand the EAP services and confidentiality policies, as well as my rights and responsibilities.

Client Name (please print): _____

Client/Legal Guardian Signature: _____ Date: _____

EAP Counselor Signature: _____ Date: _____

OUR TECHNOLOGY STATEMENT (Optional Privacy Request.)

EAP Works will maintain your privacy and keep your information confidential. As more clients request distance counseling, we are obligated to remind you that **cell phones, computers, and emails/text messages may not always be secure**. Please initial the box to the right of each item below to indicate if we may contact you electronically.

Initial below to indicate your consent for communication					
Contact by Cell Phone	**Initial**	**Unencrypted Email**	**Initial**	**Unencrypted Text**	**Initial**
For Appointments		For Appointments		For Appointments	
Between Sessions		Between Sessions		Between Sessions	
Emergency Contact		Emergency Contact		Emergency Contact	

Also, please provide a person that we may contact on your behalf if necessary.

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone: _____ Email: _____

2

EAP WORKS RELEASE OF INFORMATION

3355 Medlock Bridge Road
Norcross, GA 30092
FAX TO: (770) 449-8113 or Email to: info@eapworklife.com

With my signature below, I agree to allow EAP Works to exchange information with the following individuals and entities, as indicated by my initials:

Client Initial _____ My EAP Counselor, for payment and case coordination **(REQUIRED).**

Client Initial _____ Human Resources Dept., Name: _____

Client Initial _____ Medical doctor, Name: _____

Client Initial _____ Psychiatrist, Name: _____

Client Initial _____ Treatment Center, Name: _____

Client Initial _____ Other Referrals (specify): _____

I consent to the release of information and/or records in order to facilitate the following:

(Check only the conditions that apply)

☐ I permit the EAP Coordinator to contact my H. R. Dept. about my participation in EAP services. (Only dates of service, participation, and acceptance of referrals will be disclosed.)
☐ Summary of and/or verification of participation in treatment/counseling.
☐ Drug testing results.
☐ Referral for psychiatric evaluation or medication.
☐ Referral for hospitalization assessment.
☐ Other: _____

I understand that my records are treated confidentially as provided for under various state and federal regulations, and only the information I have approved may be communicated to the above party with my consent.

This release of information will expire at the following time from the date of my signature: ☐ 60 days ☐ 90 days ☐ 1 year

Client Name (please print): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(for minor under the age of 18)

Witness Signature: _____ Date: _____

3

Client Information and Demographics

(This form is optional, may use Clinician's Client Info/Demographic form)

To be filled out by EAP client

Company name:		Dept./Location/Branch:	
Employee name:		Job title:	
Client name (if different):		Relationship to employee:	
Home address:			
Date of birth:	Education level completed:	Marital status:	Gender:

How did you hear about the EAP? ☐ Work supervisor; ☐ HR; ☐ Family; ☐ Coworker; ☐ Other:

Type of counseling you are seeking (check all that apply): ☐ Individual Adult; ☐ Child/Adolescent; ☐ Couples/Relationship; ☐ Family; ☐ Adjustment Issues/ Stress; ☐ Grief; ☐ Anxiety; ☐ Depression; ☐ Anger Mgmt.; ☐ Substance Abuse; ☐ Career; ☐ Financial; ☐ Other:

Current medications:

Name of physician:	Physician phone:	Health insurance:

What prompted you to seek counseling, and what are your goals for counseling?

General Health: ☐ Excellent; ☐ Good; ☐ Poor
Eating Habits: ☐ Excellent; ☐ Good; ☐ Poor
Sleep Patterns: ☐ Excellent; ☐ Good; ☐ Poor

Have you had previous counseling? ☐ Yes ☐ No
If yes, please describe:

Circle primary concern & check additional issues

☐ Alcohol
☐ Another's Alcohol Use
☐ Drugs
☐ Another's Drug Use
☐ Anger Management
☐ Grief
☐ Anxiety
☐ Legal
☐ Violence
☐ Financial
☐ Depression
☐ Career
☐ Marital/Relationship
☐ Occupational
☐ Family
☐ Stress/Indiv Adjustment
☐ Childcare
☐ Eldercare

Alcohol/drug use in the last year, check all that apply

☐ None ☐ Weekends only ☐ Socially (1-2 times/month)
☐ 1-3 times per week ☐ 3-5 times per week
☐ More than 5 times per week
☐ Problems at work or school due to alcohol or drugs
☐ DUI/Legal issues
☐ Blackouts (little/no memory of events)
☐ Family history of substance abuse.
☐ Used alcohol or drugs to relieve emotional discomfort such as sadness, anger, boredom, sleeplessness, etc.

How do you prefer to participate in counseling? ☐ Face-to-Face; ☐ Telephone; ☐ Video/Distance Counseling

Thank you for using your EAP benefits. EAP Works provides a core set of services, including an assessment, brief counseling, and referral(s). Please be aware that when we cannot fully address your concerns with EAP sessions, we may offer a referral using your health insurance. We will make every effort to refer you to an in-network provider.

If you are unable to keep your scheduled appointment with your EAP counselor, please contact their office to let them know *at least* 24 hours before your appointment. Failure to do so will result in the loss of that EAP session. By signing below you are acknowledging that you understand the EAP services and conditions.

Client signature: _____ Date: _____

EAP Counselor signature: _____ Date: _____

4

CLIENT SURVEY

Feel free to leave this form with your EAP counselor, or send it directly to EAP Works,
Fax: (770)449-8113, Email: info@eapworklife.com
mail: EAP Works, 3355 Medlock Bridge Rd., Norcross, GA 30092

This survey is completely voluntary. It's also confidential and anonymous – and it's important! We want to provide you with the best possible EAP services. Your responses help us to ensure that your needs are being met professionally and effectively. If you do not wish to answer a particular question, please leave it blank. We also welcome your comments and suggestions. THANK YOU!

1. **My EAP counseling session was offered in a timely manner.**

   ❑ Agree ❑ Disagree ❑ Does not apply

2. **My EAP sessions were conducted at a convenient location.**

   ❑ Agree ❑ Disagree ❑ Does not apply

3. **I understand that my privacy and confidentiality are protected.**

   ❑ Agree ❑ Disagree ❑ Does not apply

4. **My EAP counselor helped me cope with my situation, and I'm handling it better.**

   ❑ Agree ❑ Disagree ❑ Does not apply

5. **Using the EAP has helped save me time and/or money because I missed little to no work.**

   ❑ Agree ❑ Disagree ❑ Does not apply

6. **I am satisfied with services provided by the EAP.**

   ❑ Agree ❑ Disagree ❑ Does not apply

OPTIONAL INFORMATION

I received services in _____.
City, State

My counselor was _____.
Name of counselor

COMMENTS AND/OR SUGGESTIONS: