STATEMENT OF UNDERSTANDING

Please read through this information and sign below.

Extent of EAP Services:
The EAP offers assessment, consultation, and short-term counseling for your personal concerns. Often short-
term counseling is completed within the allotted EAP sessions. However, the number of recommended
sessions is determined by your counselor. If the EAP counselor determines that long-term counseling or a
higher level of care is recommended, your unused EAP sessions will be ‘banked’ for future visits within
the next 12 months if needed. You will have to call Carebridge to reauthorize these sessions. If you
violate the counselor's missed session or late cancellation policy, you may forfeit one of your EAP sessions.

Completion of Leave or Legal paperwork:
I understand that it is out of the scope of the EAP to provide documentation or testimony for court or legal
issues, court-ordered counseling or treatment, evaluation or documentation for FMLA, disability, or other
work-related leave of absences. If these services are needed, please consult with a care manager at Carebridge.

Cost:
There are no charges to you or your covered family members for using the EAP services. There may be
charges however, should you be referred to, and choose to utilize, the services of other professionals. If an
outside referral is chosen, every effort will be made to find the best resource at the lowest cost to you.
Certain costs may be partially offset by your Medical Benefit Plan. I understand that it is my responsibility
to verify my medical benefit coverage and benefits for continued sessions with this Affiliate.

Confidentiality:
All records kept by the EAP will be treated confidentially. No information can be released outside the EAP
without your written consent, unless required by law. Various laws require that the EAP staff assume the
responsibility for reporting to appropriate parties instances when a person is a danger to themselves, to
others, or when elder/child abuse/neglect is involved. To keep this program confidential, your employer has
contracted with Carebridge, an independent outside benefit firm, to administer the EAP.

Formal Referrals:
If a supervisor requires that you contact the EAP (for instance, because of a performance concern), the
supervisor will not be informed of any details of your counseling without your signed consent.

Complaints:
If you have a complaint concerning any person associated with the EAP service, the quality of service
provided, or any other aspect of the EAP, you may register the complaint with Carebridge by calling 800-437-0911.

Satisfaction Survey:
As a part of quality assurance, I further authorize Carebridge to contact me to survey my satisfaction with
the services I receive.

Signature:
I have read this statement and may request a copy for my records.

CLIENT INFORMATION

Client Name: ___________________________ EAP Case #: ___________________________

By signing this statement of understanding, I agree to allow the Affiliate to invoice Carebridge EAP for my counseling
sessions, as well as provider case notes, consultation and case collaboration to Carebridge.

Client/Guardian Signature: ___________________________ Date: ___________________________
**ADULT CLIENT INFORMATION FORM**

*All identifying information is confidential, to the extent permitted by law.*

Today's Date: ________________  Been Here Before?  ☐ Yes  ☐ No  When?: ________________

Name: ____________________________________________________________

Address: __________________________________________________________

City: __________________________________ State: __________ Zip: __________

Telephones: Cell: __________________ Home: __________________ Work: ________________

OK to text an appointment reminder?  ☐ Yes  ☐ No

OK to Call?:  ☐ Cell  ☐ Home  ☐ Work  OK to Leave Message?:  ☐ Cell  ☐ Home  ☐ Work

Email: __________________________________________________________ 

OK to email?:  ☐ Yes  ☐ No

Date of Birth: ________________  Age: __________  Gender: ☐ Male  ☐ Female

Marital Status:  ☐ Single  ☐ Divorced  ☐ Widowed  ☐ Married  ☐ Partnered

Name of Spouse/Partner: ____________________________  How long married?: ____ Kids?: ____

Emergency Contact: ____________________________ Phone number: __________________

Your Employer: __________________________________________________

Job Title: ____________________________ Dept.: ____________________________

Referred by:  ☐ Self  ☐ Supervisor  ☐ HR  ☐ Co-worker/Friend  ☐ Family

Have you ever received any kind of counseling services?  ☐ Yes  ☐ No

When: ________________  Therapist: __________________________________

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The information below pertains to the Employee of the company providing this benefit.

Your status with the Employee of the company that is sponsoring this EAP visit:

☐ Self  ☐ Spouse  ☐ Partner  ☐ Child/Dependent of Employee

Name of Company Providing this Benefit: ____________________________________________

Employee Name: ____________________________ Employee's Date of Birth: __________

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Rev. 12/17  MR-1804
Welcome to the Employee Assistance Program (EAP). Your employer sponsors this EAP to help employees and family members resolve personal problems.

SERVICES:
Your EAP counselor will help evaluate your situation and develop an action plan for resolving the problem. This action plan may include additional EAP sessions (up to the limits of your company's contract with us), or you may be referred to providers outside of the EAP who have expertise in your area of need.

The EAP does not provide long-term therapy; neither does it provide specialized evaluations such as psychological testing, custody evaluations, or court-ordered evaluations. However, we will help you identify appropriate resources to meet these needs.

CONFIDENTIALITY:
EAP services are confidential. We will not reveal information about our work with you to any outside person or agency, including your employer, without your written permission. The only exception to confidentiality is by court order, or in those situations that are life-threatening, involve suspected abuse or neglect of a child or vulnerable adult, or represent the commission or threat of a crime on the EAP premises.

COSTS AND APPOINTMENTS:
EAP services are customized by the employer and usually are paid in full by the employer. Some plans may require copay after a certain number of visits. Your counselor will be able to explain the details of your plan. If you accept a referral to a provider in the community, you will be responsible for any costs associated with those services. You should check your health care benefits to determine if those costs might be covered by your health insurance.

EAP sessions will usually last 45-60 minutes. Your counselor will make every effort to begin and end the sessions on time. If you fail to appear for a session, or cancel a session with less than 24 hour notice, we will either count that session against the total allowed by the employer or you may be charged for the time that was allotted to you, depending on your plan. Your counselor will be able to answer questions about this policy.

THE SAINT ALPHONSONS EAP:
The Saint Alphonsus EAP is a department of Saint Alphonsus. All counselors have earned advanced degrees and maintain state licenses. If you have additional questions about the EAP, ask your EAP counselor or the Office Manager.

FEEDBACK QUESTIONNAIRE:
In order to monitor the effectiveness of the EAP and identify ways of improving our services. After we complete our work together we would like to send you an anonymous feedback questionnaire. Please select from the following options:

☐ Please email the questionnaire to the following address: ________________________________

☐ Please mail the questionnaire to the following address: ________________________________

☐ No, please do not send me a feedback questionnaire.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
I have been offered the Saint Alphonsus Notice of Privacy Practices that provides information about how the facility may use and disclose Protected Health Information (PHI) for purposes of treatment, payment and health care operations. ________ Please initial

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that the Patient Rights and Responsibilities brochure was offered to me and is available in the registration area and upon request. I understand the brochure includes information about visitation rights, Advance Directives, as well as information regarding other patient rights and responsibilities. ______ Please initial

I have read this statement and accept, understand, and acknowledge its conditions and contents.
**EMPLOYEE ASSISTANCE PROGRAM**

**SUMMARY LIST**

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<th>SUBSTANCE</th>
<th>REACTION</th>
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**ALLERGIES**
Adverse Drug Reaction

**CURRENT MEDICATIONS/DATES**

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**SIGNIFICANT MEDICAL OR PSYCHIATRIC ILLNESS**

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**Signature**