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: ________________

Carebridge Corporation | 40 Lloyd Avenue, Suite 204 | Malvern, PA 19355
CHILD CLIENT INFORMATION FORM

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

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

Name: __________________________ Date of Birth: ________ Age: ___ Gender: ☐ M ☐ F

Address: __________________________ City: __________ State: ___ Zip: ________

Mother's Name: _____________________ Cell: ______________ Home: ________________

Work: ________________ Ok to Leave Message?: ☐ Cell ☐ Home ☐ Work

Mother’s Email: __________________________ OK to email?: ☐ Yes ☐ No

Father's Name: _____________________ Cell: ______________ Home: ________________

Work: ________________ Ok to Leave Message?: ☐ Cell ☐ Home ☐ Work

Father's Email: __________________________ OK to email?: ☐ Yes ☐ No

Guardian/Other: ________________ Cell: ______________ Home: ________________

Work: ________________ Ok to Leave Message?: ☐ Cell ☐ Home ☐ Work

Guardian/Other Email: __________________________ OK to email?: ☐ Yes ☐ No

Marital Status of Parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: __________

If divorced, who has legal/physical custody?: __________________________

Emergency Contact: __________________________ Phone number: __________________

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

Has your child ever received any kind of counseling services? ☐ Yes ☐ No

When: __________________________ Therapist: __________________________

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

Name of Company Providing this Benefit: __________________________

Employee Name: ________________ Employee’s Date of Birth: __________________________
CONSENT TO TREAT A MINOR

Permission is granted for the Saint Alphonsus Employee Assistance Program (EAP) and its Associates and Employees to provide evaluation, counseling, and/or referral assistance to:

(Name of Minor Child)

I verify that I am the responsible parent or legal guardian of this child. I have had sufficient opportunity to discuss the condition, the proposed treatment, the likelihood of success, risks, benefits, and side effects of the proposed treatment, alternative treatments and non-treatment, and the likelihood of success, risks, benefits and side effects of such alternative treatments and non-treatment with my doctor, and all of my questions have been answered to my satisfaction.

I understand that I may revoke this consent at any time by informing, in writing to the EAP. Otherwise, this consent shall expire after a period of 90 days from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any and all liabilities arising there from.

_________________________  ______________________
Signature of Parent of Legal Guardian  Date

_________________________  ______________________
Signature of Minor (if possible)  Date

_________________________  ______________________
Signature of Witness  Date
### EMPLOYEE ASSISTANCE PROGRAM

**Client Name:**

**Client ID#:**

**Date:**

### SUMMARY LIST

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### ALLERGIES

**Adverse Drug Reaction**

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### CURRENT MEDICATIONS/DATES

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### SIGNIFICANT MEDICAL OR PSYCHIATRIC ILLNESS

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*Signature*
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 ALPHONSSUS 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.

Signature of Client or Legal Guardian ___________________ Date __________

Name of Client (Please Print) __________________________