



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **How We Safeguard Your Protected Health Information.**

Your individual information about your past, present, or future health, the health care you receive, or the payment for the health care is called "Protected Health Information" ("PHI"). This Notice explains how, when and why we may use or share your PHI. In some cases, we must use or share only minimum necessary PHI to accomplish a task. The law has special protections for information involving substance abuse.

Workplace Solutions staff member will give this Notice to you and ask that you sign a form stating that you received the Notice. You may also ask for a copy of the Notice by calling the EAP number provided by your employer.

While we follow the privacy practices described in this Notice, we are not required to and **we may change our privacy practices and this Notice at any time**. If we make changes, we will put a new Notice on our Website at www.wseap.com and also provide you a copy of the new Notice at your request.

II. **How we may use and disclose your Protected Health Information**

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
 - **Treatment** is when we provide, coordinate, or manage your health care and other services related to your health care. Treatment includes consultation with another health care provider, such as your family physician or therapist or psychiatrist.
 - **Payment** is when we obtain reimbursement for your healthcare. Payment includes disclosure of your PHI to your health insurer to obtain reimbursement for services or to determine eligibility or coverage.
 - **Health Care Operations** are activities that relate to the performance and operation of Workplace Solutions. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within Workplace Solutions such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of Workplace Solutions such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We also need to obtain an authorization before releasing your EAP contact record. This EAP record includes the assessment and record of contacts with the EAP counselor and is given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or client record) at any time provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining reimbursement, law provides the insurer the right to contest the claim under the policy.





III. Uses and Disclosure without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – If we have reason to believe that an individual protected by state law has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.
- *Health Oversight Activities* – we may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
- *Worker's Compensation* – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your assessment and EAP contact and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. Your Rights Regarding Your Protected Health Information

You have the following rights relating to your PHI. You may exercise these rights by contacting Workplace Solutions at the number in your member materials.

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records for as long as the PHI is maintained in the EAP Record. On your request, we will discuss with you the details of the access process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon request, we will discuss with you the amendment process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request.

V. Question and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have concerns about your privacy rights, you may contact our **EAP office at 800-327-5071**. If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Workplace Solutions, LLC, 19 E. Schaumburg Road, 1st floor, Schaumburg, IL 60194.



STATEMENT OF UNDERSTANDING

This statement is to inform you of the scope and limitations of the Employee Assistance Program. Your decision to consult with the EAP is voluntary whether you are here on your own or were referred by someone at your workplace. Please review the following guidelines concerning your contacts with Workplace Solutions EAP. Feel free to ask for an explanation if you have concerns.

Your contact with the EAP is confidential, except in the following circumstances:

1. Counselors are required by law to report cases of suspected child and elder abuse to authorities;
2. Counselors are required by law to inform authorities if there is a serious threat to harm yourself or someone else;
3. If you authorize a release of information to a specific person or agency, only the information that you authorize will be released;
4. Records may be subpoenaed by a court of law and released without your consent;
5. Records may be reviewed for purposes of quality and/or research. Individual identifying information will be removed from any and all reports.

You and your eligible dependents are entitled to sessions with an EAP counselor at no cost to you. If a referral for further counseling is necessary, the EAP will direct you to the most appropriate resource for your situation. This may be an independent professional, a community resource or a provider within your healthcare plan. You will be responsible for co-pays and other charges to those providers.

I have read this statement and understand its content.

Client Signature	Date
Witness Signature	Date
Counselor: initial here if obtained by phone	Date

Your feedback is instrumental in our efforts to best meet the needs of our clients. This feedback is in the form of an anonymous questionnaire sent out to clients who choose to participate and provides an opportunity for you to rate the quality of the services you have received.

_____ I agree to participate in the EAP follow-up survey. I would like the form to be mailed to the
(initial) following name and address: **(please print)**

_____ I do not wish to participate in the EAP follow-up survey.
(initial)

I hereby acknowledge receipt of Workplace Solutions' Notice of Privacy Practices.

Client Initials	Witness Initials	Date
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Indicate how delivered: _____ in person _____ email _____ mail _____ fax _____ website

For office use only

Contract #: _____ Company: _____ Date Sent: _____

DAYBREAK CASE OPENING DATA SHEET

*OPEN AS: (Check one): 1___ NEW CASE 2___ CLIENT CONSULT (Enter Name & Phone) ___ REOPENED CASE

*CLIENT FIRST NAME _____ *(MI) _____ *(LAST) _____ ID# _____ *OPEN DATE: ___/___/___
(ID is AUTOMATICALLY ASSIGNED- YOU CAN OVERRIDE)

*EMPLOYEE FIRST _____ *(MI) _____ *(LAST) _____ *CLIENT DOB: ___/___/___ AGE _____

*ADDRESS _____ *CITY _____ *STATE _____ *ZIP _____ EMAIL _____

*WORK PHONE (____) _____ - _____ Ext _____ Y/N OK to call? *HOME PHONE (____) _____ - _____ Y/N OK to call? *CELL PHONE (____) _____ - _____ Y/N OK to call?

HEALTH PLAN:

***EDUCATION**

- 1___ 8 grades or under
- 2___ 9th through 11th
- 3___ H.S. Graduate
- 4___ Some College
- 5___ College Graduate
- 6___ Advanced Degree
- 7___ Data Not Available

***ETHNIC BACKGROUND**

- 1___ Caucasian
- 2___ African American
- 3___ Hispanic
- 4___ Native American
- 5___ Asian
- 6___ Other
- 7___ Data Not Available

***GENDER**

- 1___ Male
- 2___ Female
- 3___ Data Not Available

***MARITAL STATUS**

- 1___ Single
- 2___ Married
- 3___ Divorced
- 4___ Separated
- 5___ Widowed
- 6___ Living w/Someone
- 7___ Data Not Available

***STAFF/AFFILIATE:**

***CASE WAS OPENED ON:**

- 1___ Employee Only
- 2___ Employee & Family Member
- 3___ Family Member Only
- 4___ Other
- 5___ Data Not Available

***REFERRAL SOURCE**

- 1___ Supervisor Formal
- 2___ Supervisor Informal
- 3___ Employee Health / HR
- 4___ Self
- 5___ Insurance Card
- 6___ Data Not Available

COMPANY NAME, WORK LOCATION, CITY & STATE

JOB TITLE

WORK STATUS

- 1___ Full Time
- 2___ Part Time
- 3___ On Leave
- 4___ Retired
- 5___ Other

- 6___ N/A Family Member
- 7___ Data Not Available

***BEEN TO EAP BEFORE**

- 1___ No
- 2___ Once
- 3___ Twice
- 4___ Three Times
- 5___ Four Times
- 6___ Five or More Times
- 7___ Data Not Available

SHIFT

- 1___ Days
- 2___ Evenings
- 3___ Nights
- 4___ Rotating
- 5___ Other
- 6___ N/A Family Member
- 7___ Data Not Available

LENGTH OF SERVICE

- 1___ Under 1 Year
- 2___ 1 - 3 Years
- 3___ 4 - 6 Years
- 4___ 7 - 9 Years
- 5___ 10 - 15 Years
- 6___ 16 or More Years
- 7___ N/A Family Member
- 8___ Data Not Available

WORK PERFORMANCE PROBLEMS

(Mark #1 and #2 if applies #1 being the most serious)

- 1___ Absent
- 2___ Tardy
- 3___ Safety Violations
- 4___ Problems Relating to Other Employees
- 5___ Quality/Quantity of Work Decreased
- 6___ Workers Comp Case
- 7___ Alcohol/Drugs Suspected on the job
- 8___ Theft
- 9___ Other
- 10___ N/A Family Member
- 11___ NO PROBLEMS
- 12___ Data Not Available

PERSONNEL ACTIONS TAKEN

(Mark #1 and #2 if applies #1 being the most serious)

- 1___ Employee was counseled
- 2___ Verbal/Written Warning
- 3___ Suspension
- 4___ Demotion
- 5___ Termination
- 6___ Resignation
- 7___ NO ACTION TAKEN

- 8___ N/A - Family Member
- 9___ Other
- 10___ Data Not Available

SELF REPORTED DAYS ABSENT IN LAST 12 MONTHS

- 1___ No Days
- 2___ 1 - 5 Days
- 3___ 6 - 10 Days
- 4___ 11 - 15 Days
- 5___ 16 + Days
- 6___ N/A - Family Member
- 7___ Data Not Available

HAVE YOU LOST TIME AT WORK DUE TO INJURY IN LAST 12 MONTHS

- 1___ Yes
- 2___ No
- 3___ N/A Family Member
- 4___ Data Not Available

***URGENCY OF THE CASE**

- 1___ Suicide
- 2___ Homicide
- 3___ Sexual Abuse
- 4___ Physical Abuse
- 5___ Psychosis
- 6___ Combination of Above
- 7___ None of Above
- 8___ Data Not Available

***AWARE OF EAP FROM:**

- 1___ Prior Participation
- 2___ Printed Material
- 3___ Posters
- 4___ Website
- 5___ Other On-Site Activity
- 6___ Supervisor Suggested
- 7___ Co-Worker Suggested
- 8___ Family Suggested
- 9___ Training/ Orientation / Seminar
- 10___ Other
- 11___ Data Not Available

***PERSONAL ISSUES AS PRESENTED BY CLIENT**

1 _____ 2 _____

**From the following list, enter #1 and #2, if applies, #1 being the most serious:

- Abuse / Addiction of Client*
- 1___ Alcohol Abuse
- 2___ Drug Abuse
- 3___ Gambling
- 4___ Internet
- 5___ Sexual
- 6___ Abuse Other Family
- 7___ Family Conflict

- 8___ Child
- 9___ Teen
- 10___ Parent / Child Relationship
- 11___ Domestic Violence
- 12___ Reaction to Illness
- 13___ Living with Abuse or Addiction
- 14___ Living with Emotional Problem
- 15___ Family Other
- Marital / Relationship*
- 16___ Marital / Relationship
- Emotional Problems*
- 17___ Depression
- 18___ Anxiety
- 19___ Emotional Other
- Trauma and Abuse*
- 20___ Physical Abuse
- 21___ Sexual Abuse
- 22___ Emotional Abuse
- 23___ Post Traumatic Stress
- 24___ Trauma Other

- Work Related*
- 25___ Relationship with co-workers
- 26___ Relationship with Supervisor
- 27___ Work Place Violence
- 28___ Harassment
- 29___ Job Performance
- 30___ Work Related Other

- Medical Condition*
- 31___ Medical Condition
- Financial*
- 32___ Financial Planning
- 33___ Debt
- 34___ Financial Other Legal
- 35___ Legal

- Work / Life Balance*
- 36___ Childcare
- 37___ Older Adult Services
- 38___ Lifestyle / Wellness
- 39___ Consumer Issues
- 40___ Travel / Recreation
- 41___ Home Repair
- 42___ Pet Care
- 43___ Education
- 44___ Work Life Other

- No Personal Issue*
- 45___ No Personal Issue

- Other*
- 46___ Eating Disorders
- 47___ Stress
- 48___ Not Listed

- Data Not Available*
- 49___ Data Not Available

* = ENTER ONLY THESE ITEMS FOR A CASE OPENED FAMILY MEMBER ONLY.



Progress Notes

CLIENT: _____	ID#: _____
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STAFF NAME: _____ **DATE:** _____

COMPANY: _____

Types of Contact:

Assessment Visit

No Show/ Cancellation

Follow Up Visit

Phone Assessment

Initial Intake

Case Management

Supervisor Consult

Release/Revoke/Disclose PHI

Time Spent:

Brief Summary of Session:

Follow Up Plan:



**WORKPLACE SOLUTIONS EAP
AUTHORIZATION FOR RELEASE OF INFORMATION**

I, _____, authorize _____ of Workplace Solutions EAP
Name of client Name of counselor

To disclose to _____
Name or title of person(s) or organization(s)

the following information: _____
_____.

I also authorize disclosure to _____
Name or title of person(s), organization (s) or insurance entities

The following information: _____
_____.

The purpose or need for such disclosure is: _____.

I understand that I may revoke this consent at any time, in writing, unless the program that is to make the disclosure has already done so. If not previously revoked, this consent will expire one year from the date noted below. I understand I have the right to inspect and copy the information that is to be disclosed.

- I understand that if I refuse to consent to this release of information, the following consequences may apply:
- ___ Inability of the EAP to provide comprehensive assessment, referral and follow-up services
 - ___ Discontinuity of care due to the inability to disclose pertinent information to appropriate parties
 - ___ Other _____

Signature of Client

Date

Signature of Parent/Guardian/Legal Representative

Date

Signature of Witness

Date

Notice of Recipient: Under Illinois and Federal confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such disclosure.



DAYBREAK CLIENT CLOSING DATA

NAME: (FIRST) _____ (LAST) _____ DATE CLOSED: ___/___/___

PERSONAL ISSUE AS ASSESSED BY COUNSELOR 1. _____ 2. _____

****From the following list, enter #1 and #2, if applies, #1 being the most serious:**

<p>Abuse / Addiction of Client</p> <p>1__ Alcohol Abuse</p> <p>2__ Drug Abuse</p> <p>3__ Gambling</p> <p>4__ Internet</p> <p>5__ Sexual</p> <p>6__ Abuse Other</p> <p>Family</p> <p>7__ Family Conflict</p> <p>8__ Child</p> <p>9__ Teen</p> <p>10__ Parent / Child</p> <p>Relationship</p> <p>11__ Domestic Violence</p> <p>12__ Reaction to Illness</p> <p>13__ Living with Abuse or Addiction</p> <p>14__ Living with Emotional Problem</p> <p>15__ Family Other</p> <p>Marital / Relationship</p> <p>16__ Marital / Relationship</p>	<p>Emotional Problems</p> <p>17__ Depression</p> <p>18__ Anxiety</p> <p>19__ Emotional Other</p> <p>Trauma and Abuse</p> <p>20__ Physical Abuse</p> <p>21__ Sexual Abuse</p> <p>22__ Emotional Abuse</p> <p>23__ Post Traumatic Stress</p> <p>24__ Trauma Other</p> <p>Work Related</p> <p>25__ Relationship with co-workers</p> <p>26__ Relationship with Supervisor</p> <p>27__ Work Place Violence</p> <p>28__ Harassment</p> <p>29__ Job Performance</p> <p>30__ Work Related Other</p> <p>Medical Condition</p> <p>31__ Medical Condition</p> <p>Financial</p> <p>32__ Financial Planning</p> <p>33__ Debt</p> <p>34__ Financial Other</p>	<p>Legal</p> <p>35__ Legal</p> <p>Work / Life Balance</p> <p>36__ Childcare</p> <p>37__ Older Adult Services</p> <p>38__ Lifestyle / Wellness</p> <p>39__ Consumer Issues</p> <p>40__ Travel / Recreation</p> <p>41__ Home Repair</p> <p>42__ Pet Care</p> <p>43__ Education</p> <p>44__ Work Life Other</p> <p>No Personal Issue</p> <p>45__ No Personal Issue</p> <p>Other</p> <p>46__ Eating Disorders</p> <p>47__ Stress</p> <p>48__ Not Listed</p> <p>Data Not Available</p> <p>49__ Data Not Available</p>
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DISPOSITION OF CASE

- 1__ Successful - Problem Resolved
- 2__ Problem Improved
- 3__ Problem Unimproved
- 4__ Problem Worsened
- 5__ Unable to Determine - Client Discontinued Contact
- 6__ Other
- 7__ Data Not Available

WAS A REFERRAL MADE TO AN OUTSIDE PROVIDER?

- 1__ Yes (IF YES, CONTINUE)
- 2__ No (IF NO, FORM IS COMPLETE)

REFERRALS MADE TO (Enter #1 on line of major referral & #2 on secondary referral & #3 as tertiary referral)

- 1__ Chemical Dependence IP/Residential
- 2__ Chemical Dependence OP/Day & Evening
- 3__ Mental Health IP/Residential
- 4__ Mental Health OP/Day & Evening
- 5__ Outpatient Groups
- 6__ Legal
- 7__ Financial
- 8__ Self Help
- 9__ Practitioner-M.D.
- 10__ Practitioner-Ph.D.
- 11__ Practitioner-Masters
- 12__ Social Service Agencies
- 13__ Other
- 14__ Data Not Available

REFERRED TO: _____ (Specify facility / person)

CLOSING NOTE: _____

AFFILIATE BILLING FORM

Payment Payable to (Group Name if applicable): _____

Affiliate Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SS# / Tax ID# _____ Rate: \$ _____.00/Clinical hr

Client Name: _____ Client ID number: _____

Employee Name (if not client): _____

Company Name: _____

Date of Service	Type of Service	Time Spent	Amount Due
TOTAL DUE			

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Case Manager Initials: _____ Date Received: _____

Date Approved: _____ Date Denied: _____

VP Approval Signature: _____ GL Account #: _____

STC: _____ A&R: _____ Rating: 5 4 3 2 1

Total Number of Sessions: _____