# Statement of Understanding

This statement is to inform you of the scope and limitations of the Employee Assistance Program (EAP). 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, within the limits prescribed by law. In general, no information about your contact with the EAP will be released without your written consent, 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 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 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 by:

Email address: _____ Print name: _____

-OR-

U.S. Mail sent to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ I do not wish to participate in the EAP follow-up survey.

_____

***I acknowledge being made aware of the posted Notice of Privacy Practices and upon request I will receive a copy.***

_____ _____ _____
Client initials Witness initials Date

How was this information delivered? In person Email Mail Fax Website

| ***For office use only.*** | | |
|---|---|---|
| _____ | _____ | _____ |
| Contract number | Company | Date Sent |