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, 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 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 by:

Email (please print your name & email address): ____

OR

US Mail (please print name & address):

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

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

Indicate how delivered: _____ in person _____ email _____ mail _____ fax _____ website

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For office use only

Contract #:_____________ Company: ______________________________ Date Sent: __________________