

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.

Contract number	Company			Dat	e Sent
		For office use o	nly.		
How was this information delivered?	In person	Email	Mail	Fax	Website
Client initials	Witness initials		Da	ate	
l acknowledge being made awa	are of the posted	Notice of Priva	cy Practices and	upon request I w	vill receive a copy.
I do not wish to participate in th	e EAP follow-up si	urvey.			
City:			State:		ip:
Add	ress:				
U.S. Mail sent to: Nan	ne:				
-OR-					
Email address:	Print name:				
I agree to participate in the EAF	ofollow-up survey	by:			
Your feedback is instrumental in our equestionnaire sent out to clients who clhave received.					
Counselor (initial if obtained by phone)			Date		
Witness Signature	Date				
Client Signature	Da	ite			
I have read this statement and understan	nd its content.				