



STATEMENT OF UNDERSTANDING

EAP BENEFIT AND FEES FOR SERVICE

The Tanner EAP is offered as a benefit to you by your employer. Depending on the specific contract, you may be allowed between five and eight visits per year per employee or family member. The visits are intended to provide (1) problem assessment, (2) short term counseling where appropriate and (3) referral to additional resources when necessary.

These benefits are provided at no cost to you. You are, however, responsible for any costs incurred as a result of referrals to the extent that those services may not be covered by your insurance provider.

CONFIDENTIALITY

Confidentiality is the cornerstone of any mental health service. The problems you bring to the EAP office will remain confidential and private unless you give your written permission for the counselor to share those concerns with specific other persons. **There are some exceptions that may be required by Georgia law.** Those include: (1) threats of self harm, (2) threats of harm toward others, (3) suspected abuse of children, elderly or disabled persons and (4) a valid court order. In the case of the first three, the EAP professional is ethically and legally responsible for determining whether or not information you reveal constitutes an actual threat. Your case may also be reviewed within the EAP office for the purpose of supervision, training or direction of professional staff.

In addition, some employers (i.e. public safety, DOT, aviation, nuclear power, etc.) have policies or are required by federal law to conduct fitness-for-duty evaluations as regards safety sensitive positions. As such, your EAP counselor may be required to disclose information regarding any unsafe behavior that violates those policies or regulations.

APPOINTMENTS AND HOURS OF SERVICE

In general, Tanner EAP services are provided by appointment. Walk-ins will be accepted as time permits. Should you need to cancel or reschedule an appointment we ask that you call at least 24 hours ahead in order to make that appointment time available to another client.

Our usual office hours are Monday through Friday from 8:30 AM until 5:00 PM. Additional hours may be available on a case-by-case basis. If such is the case, you should discuss that need with your counselor.

AFTER HOURS AVAILABILITY

Tanner EAP maintains after hours response 24/7 through a professional answering service. If you identify that you have a need for an immediate call back, the service will page the on-call counselor who will return your call within the hour. Otherwise, you can expect that the counselor or administrative assistant will respond to your call the next business day.

If you have a mental health or medical emergency you should contact or go to the nearest hospital emergency department for immediate assistance.

I understand the above statements and have had the opportunity to ask about and discuss any related concerns.

Client or Guardian Signature

Date

Witness

Date

GENERAL INFORMATION

Client Name _____ Address _____
 City _____ State _____ Zip _____
 Home# _____ may we call you at home? Y N may we leave a message? Y N
 Work# _____ may we call you at work? Y N may we leave a message? Y N
 Cell# _____ may we call your cell? Y N may we leave a message? Y N
 Race _____ Sex: F M Age _____ Date of Birth _____
 Place of Birth: _____ Marital Status: S M D W N/A Length of Marriage _____
 Education: Elementary ___ GED ___ High School ___ College ___ Graduate School ___

In the event we need to contact you, what number is best for you? (_____) _____ - _____

Employment

Employer _____ Length of time with current employer _____
 Job Title _____

Referral Source (answer all that apply)

Self ___ Co-worker ___ Family member ___ Human Resources ___ Physician ___
 Supervisor: Encouraged ___ Required ___

Presenting Problem

What are you experiencing that led you to make this appointment? _____

Has this ever been a problem before? Y or N

Is your present stress affecting your job performance? Y or N

Current Symptoms. (✓Check all that apply.)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> loss of interest | <input type="checkbox"/> inability to enjoy life | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sleep disturbance |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting | <input type="checkbox"/> fatigue | <input type="checkbox"/> racing heart |
| <input type="checkbox"/> trembling | <input type="checkbox"/> dry mouth | <input type="checkbox"/> feeling worthless | <input type="checkbox"/> feeling smothered |
| <input type="checkbox"/> choking | <input type="checkbox"/> nausea | <input type="checkbox"/> trouble thinking | <input type="checkbox"/> thoughts of harming others |
| <input type="checkbox"/> fear of dying | <input type="checkbox"/> fear of travel | <input type="checkbox"/> arm/leg pain | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> angry outbursts | <input type="checkbox"/> fear of "going crazy" | <input type="checkbox"/> pressure/constriction in chest |
| <input type="checkbox"/> hot flashes | <input type="checkbox"/> flashbacks | <input type="checkbox"/> feeling on edge | <input type="checkbox"/> easily startled |
| <input type="checkbox"/> chills | <input type="checkbox"/> painful periods | <input type="checkbox"/> smothering | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low self-esteem | <input type="checkbox"/> irritability | <input type="checkbox"/> loss of energy |
| <input type="checkbox"/> sweating | <input type="checkbox"/> restlessness | <input type="checkbox"/> feeling hopeless | <input type="checkbox"/> lump in throat |
| <input type="checkbox"/> forgetfulness | <input type="checkbox"/> recent weight changes | <input type="checkbox"/> drinking too much | <input type="checkbox"/> sudden/intense anxiety |
| <input type="checkbox"/> racing thoughts | | | <input type="checkbox"/> thoughts of harming myself |

Substance Abuse/Mental Health History

If you have ever used? When? Tobacco _____ Alcohol _____ Marijuana _____ Cocaine _____
Narcotics _____ Hallucinogens _____ Amphetamines _____ "Meth" _____ Other _____

Has anyone in your family ever had an alcohol or other drug problem? **Y or N**

Have you ever felt you should cut down on drinking or drug use? **Y or N**

Have people annoyed you by criticizing your drinking or drug use? **Y or N**

Have you ever felt guilty about your drinking or drug use? **Y or N**

Have you ever taken a drink or drug in the morning (as an eye opener) to steady
your nerves or get rid of a hangover? **Y or N**

Is there any history of physical or sexual abuse in your family? **Y or N**

Have any family members ever had psychological or emotional problems? **Y or N**

Physical Health

Do you exercise? **Y or N** If so, how often? _____

When was your last physical? _____ Are you under the care of a physician? **Y or N**

If yes, who and what for? _____

Do you have any chronic physical problems? _____

Medications taken regularly:

| Name | Reason | Dosage | Physician |
|-------|--------|--------|-----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Spiritual/Self Care

To whom do you turn for strength? _____

What religious practices, if any, do you find helpful? _____

What, if any, are the alternative health care practices that you routinely participate in?

FAMILY INFORMATION

Spouse/Significant Other (if applicable)

Name _____ Age _____

Occupation _____ Employer _____

Children OR Siblings

| NAME(s) | AGE | SEX |
|---------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Parents

Mother: Living **Y or N** If yes, age _____ number of times married _____

Father: Living **Y or N** If yes, age _____ number of times married _____



**HIPAA NOTICE OF PRIVACY PRACTICES
CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT,
PAYMENT, AND HEALTH CARE OPERATIONS (TPO)**

Federal regulations (HIPAA) allow us to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for services we provide, and for other professional activities (known as “health care operations”). Nevertheless, we ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

I also acknowledge that I have received or have been offered a copy of the HIPAA Notice of Privacy Practices from Tanner EAP. I also understand that I may ask questions about any part of the notice that I may not understand.

Client or Guardian

Date

Signature

Witness

Date

Signature