



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



To be completed by the parent or medical legal guardian requesting services for a minor child

Background Information:

Name of Child: _____ Age _____ DOB _____ Race _____

Name of person(s) child resides with _____

Relationship to Child: Biological Parent - Parent & Step Parent - Grandparent - Other

Residing Address: _____ City _____ State _____ Zip _____

Mailing Address: _____ City _____ State _____ Zip _____

Home Telephone # _____ Work _____ Cell _____

Emergency Contact – Name _____ Number _____ Relationship _____

If parents are separated or divorced, for how long? _____ Who has custody? _____

Other Biological Parent – Name _____

Referral Source: _____

School Name: _____ Grade _____

Primary Physician: _____ Tel # _____

Immediate Family Members: Names Age(s) ✓ if lives with client

Brother(s) _____

Sister (s) _____

Other _____

In your own words, briefly describe the main problem which prompted you to seek counseling for your child:

Problem areas: In the following list place a check mark✓ next to each item which identifies an area of concern to you. Place two checks✓✓ by those items, which are most important.

- | | | |
|--|---|---|
| <input type="checkbox"/> Anger/temper | <input type="checkbox"/> Sexual Concerns | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thoughts of Suicide | <input type="checkbox"/> Educational/ School work | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Use of Alcohol | <input type="checkbox"/> Fearfulness/ Phobia |
| <input type="checkbox"/> Use of Tobacco | <input type="checkbox"/> Physical Problems | <input type="checkbox"/> Excessive Caffeine |
| <input type="checkbox"/> Work | <input type="checkbox"/> Worry | <input type="checkbox"/> Marital Problems |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Stress | <input type="checkbox"/> Religious/ Spiritual Concerns |
| <input type="checkbox"/> Insecure/Timid/ Lack of Self Confidence | | <input type="checkbox"/> Traumatic Stress |
| <input type="checkbox"/> Problems with accepting discipline | <input type="checkbox"/> Current substance use: <input type="checkbox"/> Marijuana <input type="checkbox"/> Narcotics | |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Acid <input type="checkbox"/> Cocaine <input type="checkbox"/> Alcohol <input type="checkbox"/> Prescription |
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Other | |
- If checked, frequency of use:***
-

Has your child ever been the victim of or witnessed any type of traumatic incident? If yes, please explain: _____

Medical History

List sicknesses, operations, and injuries. Indicate age when occurred and describe briefly.

Has there been any previous counseling or psychological, psychiatric, neurological, or EEG evaluations? If so, please list names, addresses and dates of contact.

Indicate any continuing medication treatment. _____

When did the child last have a physical examination? _____

Name and address of Physician:

Describe and developmental problems (such as walking and talking) : _____

Describe and method of discipline used and how the child reacts to such discipline. _____

Describe the child's appetite and eating habits currently: _____

Describe nervous habits such as thumb sucking, nail biting, etc: _____

Describe child's sleeping pattern now. Are there nightmare or night terrors now or in the past? _____

Describe the child's level of activity and vigor. _____

Describe any problems in attention or sitting still. _____

Food or Drug Allergies? _____

Any Moodiness? _____

Academic / School Information

Name of school _____ Grade _____

Has child ever repeated a grade? _____ If so, when? _____

Describe what the child likes to do for fun, special interest, hobbies, etc: _____

Please add any additional comments which you wish to tell your counselor: _____

Parent/Guardian Name: _____

Relationship _____

Date _____



**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