YOUR PERMISSION PLEASE!

We need to know the best way to reach you to remind you of your scheduled EAP appointment. We may also need to contact you if your appointment needs to be rescheduled for any reason.

The best way to contact me is by:

- ☐ Cell Phone _____
- ☐ Work Phone _____

Preferred Appointment Reminder Method:

- ☐ Text Message Phone carrier: (required to for text message) _____
- ☐ Email Email Address: _____

Please select:

- ☐ I Do **NOT** want appointment reminders.
- ☐ I give Allen EAP permission to call the above numbers provided for urgent needs.
- ☐ It is OK to leave a message with _____Relationship _____
- ☐ Do **NOT** call me for **any reason**.

Printed Client Name: _____

Signature: _____ Date: _____

Signing this form doesn't guarantee you will be called as a reminder. It does, however, give us permission to contact you. If at any time you change your mind, please let your counselor or the schedulers know. THANK YOU!

UnityPoint Health

EMPLOYEE ASSISTANCE PROGRAM
STATEMENT OF UNDERSTANDING

PROGRAM ELIGIBILITY AND COSTS

Allen Hospital Employee Assistance Program offers CONFIDENTIAL assessment, short-term counseling and referral, if necessary. EAP services are provided by your employer at no cost to you, the employee, your spouse, or your dependent.

Referrals to service providers outside of the EAP may be recommended to help you resolve your issues. These services may be covered under a medical benefit plan offered by your employer, insurer or HMO. However, it is your responsibility to determine whether or not these referral services are covered under any such plan and to pay any charges not covered.

CONFIDENTIALITY:

All EAP information regarding clients is kept strictly **CONFIDENTIAL:**

1. The EAP client's employer and/or family members will not know that they have used EAP services unless written permission is provided by the client to disclose this information to them.
2. No EAP client information will be released unless the EAP client signs a release of information form. If a release of information form is signed, the EAP client will be informed of the specific information to be released.
3. EAP clients who are Supervisor Referrals will sign a release of information to the referring employer for the EAP counselor to disclose appointment times/dates and depending on the situation, to disclose any recommendations.
4. No EAP client information with be shared between EAP counselors when additional/different counseling services are provided (individual or couples or family sessions) unless a release of information form is signed by each client for information to be disclosed to the new counselor providing the different counseling service.
5. No identifying information re: EAP clients is disclosed when companies are billed for EAP services.
6. All EAP client records are retained in the EAP department and are not part of Allen Hospital's medical record system.
7. Legal requirements mandate the EAP staff to report life-threatening circumstances, including danger to self or others; child abuse; and dependent adult abuse.

If a client is a minor child (EAP ONLY/NOT FOR SUBSTANCE ABUSE): I give permission for my minor child to receive EAP services from the Employee Assistance Program. I certify that I am the legal parent/guardian of the minor child with the legal authority to give such permission. I authorize the following person(s) to participate in the assessment, counseling and treatment planning of my minor child:

_____ _____

I have read, understand, and agree to the conditions described in this form.

_____ _____

Signature of Client or Legal Guardian for Date

_____ _____

PRINT Client's Name Witness

UnityPoint Health

EMPLOYEE ASSISTANCE PROGRAM
TELEHEALTH STATEMENT OF UNDERSTANDING

There are possible limitations and risks associated with telehealth services:

1. In the event of counseling over the telephone or tele-health, it is the responsibility of the client to create a confidential environment on their end of the phone or tele-health conversation as well as establish a secure phone line or internet connection.
2. The tele-health counseling electronic systems used by Allen Hospital will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
3. Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.
4. I understand that tele-behavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
5. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.
6. In rare instances, security protocols could fail, causing a breach of privacy of personal health information.

I have read, understand, and agree to the conditions described in this form.

_____ _____

Signature of Client or Legal Guardian for Date

_____ _____

PRINT Client's Name Witness

UnityPoint Health

EAP ADULT INTAKE FORM

Today's Date _____ **DOB**: _____

Client Name_____

Address _____

Street City State Zip Code

Phone: (Home):_____ (Work): _____ (Cell): _____

May we contact you at home? ☐Yes ☐No **May we contact you at work?** ☐Yes ☐No

How did you learn about EAP?

☐Company Media ☐EAP Media ☐Co-worker ☐Family ☐Friend ☐Other

Who referred you to EAP?

☐Self ☐Company ☐Family ☐Medical ☐Peer ☐Co-worker ☐Supervisor ☐Other

My EAP benefit is through: ☐My company/employer ☐My spouse/family member's company

Company Name: _____

Your Work Information:

Employer: _____

Occupation: _____

Length of Employment: _____ Work Status: ☐FT ☐PT

Job Satisfaction: ☐Satisfied ☐Unsatisfied ☐Neutral

Do you feel your presenting issue affects your job performance? ☐Yes ☐No ☐Not sure

What is your primary insurance company: _____

Family Information:

Marital Status: ☐Single ☐Married ☐Divorced ☐Cohabitating ☐Separated ☐Widowed

Spouse/Partner's name: _____ Age: _____

Children's names: _____ Age: _____

_____ Age: _____

_____ Age: _____

What is the highest level of education you have completed? _____

Medical/Mental Health Information:

How would you describe your current health? ☐Good ☐Fair ☐Poor

Current doctor(s):_____

Current prescription medications, over-the-counter medications or herbal preparations (name and dosage):

_____ _____ _____

_____ _____ _____

Any known allergies? ☐Yes ☐No If so, please list: _____

Describe any adverse/allergic reactions:

Medical/Mental Health Information, cont.:

Please list any significant medical diagnosis and conditions:

_____ _____ _____ _____

_____ _____ _____ _____

Have you been hospitalized for any medical, past surgeries, or mental health reason? ☐ Yes ☐ No

Diagnosis _____ Year _____ Diagnosis _____ Year _____

Diagnosis _____ Year _____ Diagnosis _____ Year _____

Diagnosis _____ Year _____ Diagnosis _____ Year _____

Check any that you are presently experiencing:

☐ Chest pains	☐ Physical pain	☐ Excessive sweating
☐ Hot flashes	☐ Confusion	☐ Fainting spells
☐ Headaches	☐ Vomiting	☐ Seizures
☐ Change in appetite	☐ Numbness	☐ Shortness of breath
☐ Fatigue	☐ Tremor/Shaking	☐ Weight loss/gain
☐ Racing thoughts	☐ Sleep disturbance	☐ Hopelessness
☐ Mood swings	☐ Irritability	☐ Crying spells
☐ Angry outbursts	☐ Concentration	☐ Thoughts of hurting self
☐ Difficulty at work	☐ Difficulty at home	☐ Difficulty at school

Are there any other health problems that you feel we should know about? ☐ Yes ☐ No

If so, please explain: _____

Alcohol use? ☐ Yes ☐ No

Drug use? ☐ Yes ☐ No

Caffeine use? ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No

Have you ever participated in treatment for any of these? ☐ Yes ☐ No

Have you ever had marital/mental health/psychiatric counseling? ☐ Yes ☐ No

Has anyone in your family had substance abuse or mental health concerns? ☐ Yes ☐ No

Legal Information:

Do you have any legal issues currently affecting your life? ☐ Yes ☐ No

Problem Areas: (Please check areas that apply)

☐ Drug/Alcohol	☐ Financial	☐ Gambling	☐ Domestic violence
☐ Legal	☐ Stress	☐ Depression	☐ Anxiety
☐ Physical health	☐ Physical abuse	☐ Sexual abuse	☐ Verbal abuse
☐ Eating concerns	☐ Anger	☐ Emotional abuse	☐ Marital/Relationship
☐ Sexual problems	☐ Family	☐ Job/Career	☐ Sexuality

I came to the EAP today because:

I hope to accomplish:

Client Name:_____