

# Northeast Georgia Employee Assistance Program Service Record

Appt. Date \_\_\_\_\_  
Appt. Time \_\_\_\_\_  
Location \_\_\_\_\_

1) For Office Use Only

Client Number: \_\_\_\_\_ Record Name: \_\_\_\_\_ Category: ( NEG)  Bas  Inc  
Assigned Counselor: \_\_\_\_\_ Office Location:  Athens  Winder  
Intake Date: \_\_\_\_\_ Intake Coordinator : \_\_\_\_\_  
Employer Name \_\_\_\_\_ Number of EAP Sessions Authorized: \_\_\_\_\_  
Employee Name: \_\_\_\_\_  
Is this a supervisory referral?  yes  no If yes, is it  voluntary  initiated  
If yes, supervisor contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Please complete the next section for the person identified as the primary person receiving services.  
*Example: for you-your name, for couples or families-the name of either adult, for child-the name of child.*

This information pertains to:  Employee  Dependant  
Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse/Partner Name \_\_\_\_\_  
Spouse/Partner Employer: \_\_\_\_\_

**\*\*Notice to Couples:** The record will be established in the name of the caller. Therefore any records release will require this person's signature.

Emergency Contact Name: \_\_\_\_\_ Phone \_\_\_\_\_

**Problem Statement and Scheduling needs:**

Briefly describe why you are seeking help

What, if anything, led to your contacting us at this time (i.e. recent incident, court or employer involvement, etc.)

Have you had any past treatment for these same concerns? If so, where? \_\_\_\_\_

What days/times are best for you to schedule appointments? \_\_\_\_\_

# FAMILY COUNSELING SERVICE, INC.

## FEE AGREEMENT

Funding support from the United Way allows Family Counseling Services (FCS) to provide counseling on an ability to pay basis including a lowered fee for those with no income or others who cannot afford the Agency's minimum fees.\* Ability to pay is defined as gross household income and insurance coverage as indicated below:

	Therapist	Psychologist	Other
1. Standard charge per session	\$ <u>105.00</u>	\$ <u>125.00</u>	\$ <u>105.00</u>
2. Minus amount to be paid by insurance	\$ _____	\$ _____	\$ _____
3. Remaining balance	\$ _____	\$ _____	\$ _____
4. <b>Client fee obligation</b> (co-payment) to be paid each visit (at \$1.25 per \$1,000 annual income with \$40.00 minimum)	\$ _____	\$ _____	\$ _____

\*\*Benefits quoted by your insurance carrier, including copayment are not a guarantee of payment until a claim has been filed. Therefore, please be aware that your client obligation is subject to change.

5. Amount of United Way support to be applied each visit due to ability to pay agreement (The difference, if any, between #3 and #4)	\$ _____	\$ _____	\$ _____
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\* Due to a limited number of staff openings for those requesting waiver of the standard fee, requests will be handled on a "first come-first served" basis. Anyone requesting a fee below the standard charge (\$105) must complete the work/income information on page one and provide proof of income.

Total amount of household income \$ \_\_\_\_\_ Weekly Monthly **Annually**

Your medical insurance may be used to pay a portion of the Agency's standard charges. We will file for you provided you sign the Assignment of Benefits Statement below. Clients who have insurance coverage may elect not to use it; however, they will be responsible for payment of the amount which would have been collected through insurance **in addition to** their co-payment (item #4 on above fee agreement.) If your deductible has not been met, you are responsible for the entire amount of the standard charge until the deductible has been met, payment plans are available. **Your insurance can not be billed for missed or late cancelled appointments.**

I understand that unless I give **twenty-four(24) hour notice of cancellation** I am responsible for payment.  
 X\_\_\_\_\_ Please initial. **ALSO READ AND SIGN ATTACHED PROCEDURE REGARDING MISSED APPOINTMENTS.**

### Rights To Privacy Notification

My initials here indicate I have been advised of the Notice of Privacy Practice X\_\_\_\_\_.

### ASSIGNMENT OF MEDICAL BENEFITS

I hereby assign all medical benefits which I am entitled to Family Counseling Service, Inc. A photocopy of this assignment is to be considered as valid as an original. I further authorize said assignee to release all information necessary to secure medical payments for services rendered.

Signature	Date	Birth date	Social Security Number
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Signature	Date	Birth date	Social Security Number
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Witness	Date
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## STATEMENT OF UNDERSTANDING

The Employee Assistance Program (EAP) is designed to help you and your family members manage personal problems. The EAP offers assessment, short-term counseling, referral and follow-ups services.

Your EAP counselor works with you to assess your problem and develop an appropriate action plan to help resolve that problem. This plan may include short-term counseling with your EAP counselor and/or the EAP counselor might facilitate a referral to another provider or organization with the expertise in your area of need.

All Employee Assistance services are provided at no cost to you or your family members. However, if your action plan involves seeking services outside of the EAP, the financial responsibility for payment to the referral source is yours. It is possible that the services may be coordinated through the benefit plan offered by your employer.

The information you share with your EAP counselor is confidential. Limits of confidentiality do apply, however, according to Federal Regulations, licensed clinical providers are mandated to report information that professional judgment would determine constitutes threat or serious harm to self or others, of information regarding child or elder abuse or neglect.

Disclosure of information. Under certain circumstances disclosures of information may be made:

1. When the client consents in writing.
2. When the disclosure is allowed by a valid court order.
3. When the disclosure is made to medical personnel in a medical emergency.
4. When the disclosure is made in a non-identifiable form for research, audit or program evaluation.

**I hereby certify that I have read and understand the content of the information stated above.**

### **Rights to Privacy Notification**

My initials here indicate I have been advised of the Notice of Privacy Practice \_\_\_\_\_.

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_ / 20

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Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_ / 20

**NORTHEAST GEORGIA EMPLOYEE ASSISTANCE PROGRAM**

Name of person receiving services: \_\_\_\_\_

Relationship to employee with EAP benefit: \_\_\_\_\_

*Please complete this box with information about the **Employee** with the EAP benefit.*

Name of employee with EAP benefit: \_\_\_\_\_

Employee job title: \_\_\_\_\_ Approximate date of hire: \_\_\_\_\_

Work hours: \_\_\_\_\_ Hourly or Salary? \_\_\_\_\_

Highest educational grade completed (select one): \_\_\_\_\_

Employment status (select one): \_\_\_\_\_

If "other," please describe: \_\_\_\_\_

How were you referred to EAP services? (select one): \_\_\_\_\_

Is this your first time using EAP services? (select one):            Yes            No

Primary concerns (check all that apply):

Depression/anxiety

Legal/financial

Health

Marital/family/partner

Stress

Parent/child

Anger/violence

Grief/loss

Family/life issues

Substance use/abuse

Job performance/supervisor referral

Mental/behavioral health

Other workplace concern:

**Do you feel that any of your concerns are affecting your job? Items are rated on a scale of 1-5, with 1="not at all"; 5="very much."**

Attendance: \_\_\_\_\_

Other (please explain below):

Performance: \_\_\_\_\_

Productivity: \_\_\_\_\_

## Current Concerns

Please provide the following information so we may better address your concerns. If you are completing for someone else, base on statements made to you.

### A) Areas of Concern (Rated on a scale of 1-5, where 1= "not at all"; 5= "very much")

Marriage/Partner	
Family	
Eating Habits	
Sleeping Habits	
School or Work Performance	
Ability to Concentrate	
Health	
Motivation/Energy	
Ability to Parent Children	
Ability to Manage Anger	
Ability to Trust Others	
Ability to Establish Relationships	

### B) Medical History

High Blood Pressure	
Diabetes	
Lung Problems	
Heart Problems	
Kidney Problems	
Liver Problems	
Miscarriages	
Learning Problems	
Nerve Problems	
Menopausal Symptoms	

**Current Concerns**

Mental Illness/Schizophrenia	
Depression	
Drinking Problems	
Drug Problems	
Cancer	
Seizures	
Other	

**C) Depression Inventory**

How often have you felt depressed <b>in the past two weeks?</b>	
How often have you felt tired <b>in the past two weeks?</b>	
How often have you avoided people <b>in the past two weeks?</b>	
How often have you noticed losing pleasure in things you usually care about/enjoy <b>in the past two weeks?</b>	
Have you felt depressed or sad most of the time <b>in the past year</b> , even if okay sometimes?	
Have you felt depressed or sad most of the time <b>in the past two years</b> , even if okay sometimes?	
Have you considered suicide?	
Have you attempted suicide?	

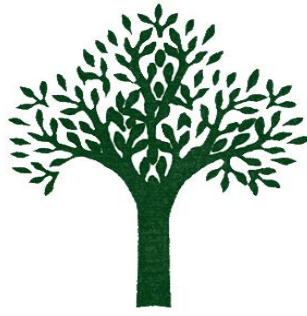
**D) Drinking/Drug Use History**

Has anyone (you or anyone significant to you) attempted to stop drinking/using other drugs?	
Has anyone (you or anyone significant to you) expressed concern about the drinking or non-prescription drug use by someone else in the home?	
Has an employer been concerned about someone's (you or anyone significant to you) alcohol/drug use?	
Has anyone had a DUI?	

**E) Prescriptions Used/Prescribed by whom:**

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## MISSED OR CANCELLED SESSIONS

As indicated on the Consent to Services form you signed at your initial visit, we ask for a 24 hour notice to cancel appointments. We understand that there may be an isolated unforeseen emergency where it is difficult or impossible to give adequate notice. Barring such rare circumstances, the following guidelines apply to missed sessions without adequate notice.

### PLEASE READ THE FOLLOWING CAREFULLY

- A. If you are using insurance for therapy, there will be a \$50 charge for a missed session. Please be aware that ***your insurance company cannot be billed if you are not present***, therefore you will be responsible for the \$50 charge regardless of your co-pay.
- B. If you are not using insurance (paying out of pocket), and your assessed fee is less than \$50 per session, you are responsible for paying your assessed fee.
- C. If you are using your Employee Assistance Program (EAP), there is no charge for a missed session; however, you will have one less session available to you.
- D. If missed appointments become a concern, your counselor will discuss this with you. Should this continue to be a problem, please be aware that FCS reserves the right to require pre-payment for sessions or even discontinue sessions.

Feel free to call FCS (706-549-7755) should you need to verify your appointment day or time. Your signature below indicates your understanding and agreement to adhere to the above policy. If you have questions about this policy please discuss them with your therapist.

\_\_\_\_\_  
Print Client/Legal Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## HIPAA Notice of Privacy Practices

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Family Counseling Service of Athens, Inc.  
1435 Oglethorpe Avenue  
Athens, Georgia 30606  
(706) 549-7755

### NOTICE TO OUR CLIENTS REGARDING NEW PRIVACY PRACTICES

As you are probably aware, federal law requires that you be notified of your rights regarding protection of information you share with us during treatment. The information on this form summarizes those rights as defined in federal law.

Signing this form only indicates you have been made aware of these rights. It does not authorize us to release any information regarding your services here. It is our policy to only release information after you have signed **our** consent form. The only exception to this is situations that are mandated by state or federal law; i.e. threat to self or others including child abuse or neglect as stated in our consent to services form which is also included for your signature.

In other words our protection policy is stricter than the federal guidelines. If you have any questions please discuss them with your therapist.

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### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### **1. Uses and Disclosures of Protected Health Information**

##### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your therapist, clinical nurse specialist, psychiatrist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a therapist, clinical nurse specialist, or psychiatrist to whom you have been referred to ensure that these individuals or organizations have the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in the course of normal business operations. These activities include, but are not limited to, case review, quality assessment activities, supervision of health care workers in training, licensing, and conducting or arranging for other business office activities. For example, we may disclose your protected health information to student interns that see clients at our office. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**Sharing Your Information:** There are situations when we are permitted, and in some instances, required to disclose information without your authorization. These situations are: when a state or federal law mandates that certain health information be reported for a specific purpose: for public health purposes, such as contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities, if any, required of us such as complaint investigations, licensing, audits, and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors; for inmates for organ and tissue donations; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for workers' compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of providing treatment, obtaining payment or office operations. For example, front office staff responsible for records maintenance and billing.

Finally, under the law, we must make disclosures to you and, if required, by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Private Practices Law.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object** unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. Under federal law, however, you may not inspect or copy the information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to law that prohibits access to protected health information, and in some instances psychotherapy notes taken by your therapist.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

However, your therapist, clinical nurse specialist, or psychiatrist is not required to agree to a restriction that you may request if the therapist, clinical nurse specialist or psychiatrist believes it is in your best interest to permit use and disclosure of your protected health information. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your therapist, clinical nurse specialist or psychiatrist amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Grace Edmonds, in person or by phone at 706-549-7755.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_