

**INSTRUCTIONS:** Please obtain during the initial assessment and retain in your record the client's signatures for the **Statement of Understanding** and **Consent to Release Information**. This form is used for billing. Complete the form in its entirety. Incomplete forms will be returned. **Please do not include previously submitted dates of service.**

### CONFIDENTIAL CONTACT HISTORY

|   |                                    |
|---|------------------------------------|
| <b>Client Name:</b>   | <b>Client SSN:</b> /    /          |
| <b>Employee Name:</b>   | <b>Employee SSN:</b> /    /        |
| <b>Client Date of Birth:</b> /    /   | <b>Client Phone Number:</b> (    ) |
| <b>Client is:</b><br><input type="checkbox"/> Employee<br><input type="checkbox"/> Spouse/Significant Other<br><input type="checkbox"/> Dependent Child | <b>Company/Division/Location</b>   |
| <b>Provider Name</b>  | <b>Provider Billing Address</b>    |
| <b>Group Organization Name</b>  | <b>City/ State/ ZIP</b>            |
| <b>Tax ID Number or EIN:</b>  | <b>Authorization Number:</b>       |
| <b>Provider Signature:</b>  | <b>Date:</b>                       |

### SERVICE HISTORY

### TREATMENT INFORMATION

| Date of Service | Billed Amount | Hrs | Type Code | With Whom | Client Engaged* | Symptom Resolution* | Work Effect Minimized* | Treatment Goal Progress* | Current GAF |
|-----------------|---------------|-----|-----------|-----------|-----------------|---------------------|------------------------|--------------------------|-------------|
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |
| / /             |               |     |           |           |                 |                     |                        |                          |             |

**Assessed Problem:** \_\_\_\_\_

**Case Status** \_\_\_\_\_ **Case Referral Type:** \_\_\_\_\_

**Diagnosis (DSM IV) Axis 1:** \_\_\_\_\_

**Client Satisfied with Treatment**  Yes  No  N/A

| Type Code                     | Case Status                           | Referral Type         | Assessed Problem                    |
|-------------------------------|---------------------------------------|-----------------------|-------------------------------------|
| 11 In Person/ Office          | 04 Open Case                          | 12 Psychiatrist       | 40 Alcohol/Drug Abuse               |
| 99 In Person/ On-Site         | 05 Case Re-Opened                     | 13 Counselor          | 41 Alcohol/Drug Abuse Family member |
|                               | 06 Closed/No Referral                 | 14 IP Psychiatric     | 42 Addiction – Other                |
|                               | 07 Closed/Client Discontinued         | 15 IP Medical         | 43 Stress                           |
|                               | 08 Closed/Refer Treatment             | 16 IP Substance Abuse | 44 Depression                       |
|                               | 09 Closed/Refer Other Assistance      | 18 OP Medical         | 45 Anxiety                          |
| <b>With Whom</b>              | 10 Closed/Continued through Insurance | 19 OP Substance Abuse | 46 Bereavement                      |
| 01 Employee                   | 11 Closed/Client Self – Pay           | 24 Self- Help Group   | 47 Anger                            |
| 02 Spouse/Child               |                                       | 27 Community Resource | 48 Other Mental Health              |
| 03 Employee and Spouse/ Child |                                       |                       | 49 Work-Related                     |
|                               |                                       |                       | 50 Violence – Abuse                 |
|                               |                                       |                       | 51 Marital Relationship             |
|                               |                                       |                       | 52 Family Issues                    |
|                               |                                       |                       | 53 Children – Behavioral            |
|                               |                                       |                       | 54 Medical                          |
|                               |                                       |                       | 55 WorkLife                         |
|                               |                                       |                       | 56 Other                            |

**\*Rate of Client Engagement, Reduction of Symptoms, Rate of Affect upon Work Performance and Treatment Goals –**

Use the Likert Scale Below: - Insert N/A if Not Applicable as part of the treatment

|  |           |              |          |              |
|--|-----------|--------------|----------|--------------|
| 1 – No Improvement/Progress/Engagement | 2 – Minor | 3 – Moderate | 4 – Good | 5 – Complete |
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## CONFIDENTIAL SERVICE PLAN & STATEMENT OF UNDERSTANDING

**INSTRUCTIONS:** Complete at end of assessment. Explain plan and Statement of Understanding to client and sign as witness. Client completes bottom section and signs form. Supply client copy, and mail original to MHNet.

### STATEMENT OF UNDERSTANDING:

1. **Extent of EAP Services.** The EAP offers assessment, consultation, and short-term counseling for your personal concerns. Often short-term counseling is completed within the allotted EAP sessions. However, the number of required sessions is determined by your counselor. If, after the initial assessment, the EAP counselor determines that long-term counseling is necessary, you will be referred out of the EAP.
2. **Cost.** There are no charges to you or your family for using the EAP services. There may be charges, however, should you be referred to – and choose to utilize – the services of the professional resources. If an outside referral is chosen, every effort will be made to find the best resource at the lowest cost to you. Certain costs may be partially offset by your Medical Benefit Plan. Contact your carrier for plan benefits and exclusions.
3. **Confidentiality.** All records kept by the EAP will be treated confidentially. No information can be released outside the EAP without your written consent, unless required by law. Various laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to themselves, to others, or when child abuse/neglect is involved.
4. **Supervisory Referrals.** A) Recommended Referrals – If a supervisor recommends that you contact the EAP (for instance, because of a performance problem), the supervisor will not be informed of your participation without your signed consent.  
B) Mandatory Referrals – The handling of mandatory referrals is in accordance with your employer's policies.
5. **Complaints.** If you have a complaint concerning any person associated with the EAP service, the quality of services provided, or any other aspect of the EAP, you may register the complaint with the 24 hour EAP Hotline by calling 1-800-492-4357.
5. **Signature.** I have read this statement and may receive a copy.

Client/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

EAP Counselor Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Client Agreement to Consent to Release Information:** I authorize the release of information to my Primary Care Physician (PCP). Information may be shared with them in order to inform and coordinate treatment.

Accept       Decline

Client/Guardian Signature \_\_\_\_\_

PCP Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Note to Recipient:** This confidential information is being disclosed to you from records that may be protected by Federal law and regulation found at USC 290dd-2 and 42CFR Part 2, dealing with confidentiality of alcohol and drug abuse patient records, as well as State law dealing with mental illness. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is permitted by written consent of the person to whom it pertains or as otherwise permitted under 42 CFR Part 2. State law may require the same. It is provided to you as the Primary Care Physician for the above named client solely for continuity of care purposes and to inform you of your patients health status. Violation of this Federal law or regulation is a crime and suspected violations may be reported to appropriate authorities in accordance with Federal regulation. Federal law and regulations do not protect any information about a crime committed by a patient or information about any threat to commit a crime, nor do they protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. The Federal rules restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient.

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| <p><b>Mail To:</b><br/>MHNet<br/>P.O. Box 7802<br/>London, KY 40742</p> |
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| <p><b>For questions regarding the EAP Program, client benefits or the Authorization please contact the MHNet EAP Division at</b></p> |
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| <p><b>(800) 492-4357</b></p> |
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| <p><b>For Questions regarding claims payment please contact MHNet Claims Service Now! at (866) 992-5246.</b></p> |
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