KeySolutions
Employee Assistance Program

Statement of Understanding & Consent for Service

KeySolutions is pleased that you have chosen to use the Employee Assistance Program (EAP). We want to make sure that you understand several things before we begin discussing your reasons for contacting us. Please read the following information, and if you do not have any questions, sign at the bottom of the page.

I understand:

- That the EAP is a voluntary service offered as a benefit by my employer, and can be used by me and my dependent family members (spouse and dependent children).
- Sessions with the EAP are provided at no direct cost to me or my family members.
- All information disclosed within sessions is confidential and may not be revealed to anyone without my written permission on a Release of Information (ROI). Any alcohol and drug treatment records are protected by Federal Regulation governing Confidentiality of Alcohol and Drug Abuse Records, 42 C.F.R., Part 2.
  The only exceptions to confidentiality are in situations where disclosure is required or allowed by law;
  - If I present an imminent threat of harm to myself or to others,
  - When there is an indication of abuse or neglect of a child or dependent adult,
  - If we receive a court order to release records,
  - If there is a medical situation that, in our judgment, requires immediate attention.
- That if I need a referral to longer-term counseling, or specialized service, I will be responsible to pay for that service. Health insurance coverage under my health benefits plan may provide some coverage of the cost of those services.
- That the EAP counselor cannot continue sessions with me beyond the EAP guidelines, without discussing other provider options with me.
- That there are risks and benefits to counseling. Talking about life events can arouse strong feelings. Dealing with problems may help improve my life, or cause greater stress. Taking personal responsibility for working on these issues may bring personal growth.
- That I have a right to decline treatment and get another opinion.
- **For Supervisory Referrals Only –** If I am required by my employer to use the EAP, KeySolutions will inform my supervisor or Human Resources representative of certain compliance information, namely, a) That I contacted the EAP, b) Date and time of appointments, c) my attendance at sessions, d) my level of cooperation, e) certain work-related recommendations. All other information requires a signed consent.

I was offered a copy of the Notice of Health Care Information Practices: Yes _____ No _____

I have read and understand this information, and hereby authorize my counselor to provide counseling services for myself and family members.

Client's signature	Date	2nd Client's signature	Date
Parent/Guardian's signature (for minor clients)	Date	Counselor's signature	Date

LABEL HERE

KeySolutions
Employee Assistance Program

New Client Intake Information

Date: _____ Reason for visit: _____

Client Name: _____ DOB: _____

Address: _____ Business/Company_____

Home Phone Number: _____ Can we leave a message: **Yes** **NO**

Cellular Phone Number: _____ Can we leave a message: **Yes** **NO**

Email address **(thereby giving permission to be contacted via email**

Please indicate (circle) which way is the best to reach you: HOME# CELL# WORK# or EMAIL

In case of emergency, notify_____ Phone Number_____

Attendee (spouse &/or children):

1._____

Name Phone DOB Relationship to Employee

2._____

Name Phone DOB Relationship to Employee

3._____

Name Phone DOB Relationship to Employee

Please answer these brief screening questions:

Question	0		1	2	3	4	
1. How often do you have a drink containing alcohol?	Never		Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day?	1 or 2		3 or 4	5 or 6	7 to 9	10+	
3. How often do you have 5 or more drinks on an occasion?	Never		Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	Never		Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
5. Are you currently having thoughts of harming yourself?	NO	YES	Explain:				
6. Are you currently having thoughts of harming anyone else?	NO	YES	Explain:				
7. Is anyone in your household physically or emotionally hurting you?	NO	YES	Explain:				

Keystone Outreach Treatment Center
NOTICE OF HEALTH INFORMATION PRACTICES

FOR MORE INFORMATION OR TO REPORT A PROBLEM

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it..

If you believe your privacy rights have been violated, you can file a complaint with the Department of Health and Human Services or Office for Civil Rights by email at OCRComplaint@hhs.gov or by calling the national Office at 202-205-8725 and ask for the ORC Health Information Privacy Complaint Form and/or for the appropriate Regional OCR Office. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We -will use your health information for treatment. For example: Information obtained by a counselor, physician, nurse or other member of your treatment care team will be recorded in your record and used to determine the course of treatment that should work best for you.

With your consent, we also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this program.

With your consent, we will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and descriptions of treatment methods and procedures used.

We will use your health information for regular, internal health operations. For example: Members of the treatment staff, the utilization review coordinator, the quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the treatment and service we provide.

OTHER USES OR DISCLOSURES

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include care by external physicians (in the event urgent or emergency care is needed), pharmacy services & filling prescriptions), and laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill for services rendered. So that your health information is protected, however, we require business associates to appropriately safeguard your information.

Notification: With your prior consent, in the event of an emergency or crisis, we may use or disclose your personal information to notify or assist in notifying a family member, personal representative, or another person(s) that you designate as responsible for your continued care, your location, and general condition.

Communication with Family: With your consent, this program's treatment personnel, using their best judgment, and disclose to a family member, other relative, close personal friend or other significant person that you identify, your personal health information that is relevant to that person's involvement in your care - or for payment needs related to your care.

Unemancipated Minor: If and to the extent, permitted or required by an applicable provision of State or other law, including applicable case law, this organization's treatment representative may disclose and provide access to protected health information about the unemancipated minor to the parent or legal guardian, or other person acting *in loco parentis.*

Research: With your consent, we may disclose information to researchers when their research has been approved by an Institutional Review Board, which has reviewed the research proposal and has established specific protocols to ensure the confidentiality of your health information.

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective date: April 14, 2003

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a health care facility, physician, or other healthcare provider, a record of your visit is made.
Typically, this record contains information about your health history, symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your client/patient or medical record, serves as a:

* basis for planning your care and treatment
* means of communication among the many health professionals who contribute to your care
* legal document describing the care you received
* means by which you or a third parry payer can verify that services billed were actually provided
* a tool in educating health professionals
* a source of data for medical research
* a source of information for public health officials charged with improving the health of the nation
* a source of data for facility planning and marketing
* a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Keystone Outreach Treatment Center
NOTICE OF HEALTH INFORMATION PRACTICES

Understanding what is in your record and how your health information is used helps you to:

* ensure its accuracy
* better understand who, what, when, where, and why others may access your health information
* make more informed decisions when authorizing disclosure to others.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

* request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 and 42 CFR, Chap.1, Part 2
* obtain a paper copy of the notice of information practices upon request
* inspect and copy your health record as provided for in 45 CFR 164.524
* obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request communications of your health information by alternative means or at alternative locations
* revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: This organization is required to:

* maintain the privacy of your health information
* provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate personal health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Continuing Care and/or Marketing: With your prior consent, we may contact you to provide appointment reminders or information about continuing care or other related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects of other information to enable the FDA to notify patients and physicians about emerging dangers.

Disability Insurance and Workers Compensation: With your consent, we may disclose the minimum health information needed to the extent authorized by and to the extent necessary to comply with laws relating to disability and workers compensation or other similar programs established by law.

Public Health: With your consent and if required by law, we may disclose the minimum necessary health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement per 42 CFR: Chapter 1, Part 2 (see Notice of "Confidentiality of Alcohol and Drug Abuse Patient Records.")

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering you or patients, workers, or the public. In this case, a court order is required per 42 CFR, Chapter 1, Part 2.

This organization reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. Revisions of this notice will be posted at this location.

Reference: Health Insurance Portability and Accountability Act (45 CFR Part 160-164) HEPAA Privacy Rule - Standards for Privacy of Individually Identifiable Health Information Adapted from the American Health Information Management Association Practice Brief, "Notice of Information Practices" (Updated November 2002); and 42 CFR, Chapter 1, Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records