HOPE Behavioral Health

541 Buttermilk Pike Suite 200
Crescent Springs KY 41017
859-869-2023

Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery

request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Patient Name _____

Sign Here _____ **Date** _____

HOPE Behavioral Health

541 Buttermilk Pike Suite 200
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859-869-2023

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Patient Name _____

Sign Here _____ **Date** _____

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Office & Communication Policies for HOPE Behavioral Health

Policy of communicating with your therapist:
-Your therapist may communicate with you via text, phone call and email for scheduling purposes only.
-Text and email messages are not guaranteed to be confidential; cell phone companies and internet service providers retain logs of all messages and content may be accessible to unknown persons. Your therapist will document and retain text and email messages as part of your permanent record.
-You may not text or e-mail your therapist in an emergency situation such as suicidal or homicidal ideations. You may try to call your therapist for guidance but if your therapist does not answer, you should proceed to the nearest emergency room if safe to do so or call 911.
-You may leave a voice mail, if safe to do so, to let you therapist know what is going on but leaving a voice mail is only for informational purposes and you should not wait for your therapist to return your call to go to the emergency room or call 911.
-You may not connect with your therapist on any form of social media. Your therapist will not accept any patient invitations to connect via Facebook, LinkedIn, Twitter, Tumblr, Instagram or any other social media site. This is to protect the integrity of the therapeutic relationship as well as our mutual confidentiality and privacy.

By signing this form, you are signing that you have read and agree to these policies and are aware that if you do not follow these policies, you are opting out of treatment with HOPE Behavioral Health and its staff.

Fees/Insurance Policy:
Hope Behavioral Health offers an affordable payment plan and works hard to support you in avoiding any unnecessary out-of-pocket costs. You may email lori@hope-nky.com at anytime to complete a payment plan.

-Please keep in mind if you have two therapy sessions in one day (example: individual and group, insurance will not pay for two therapy services in one day and you will be responsible for the uninsured amount at the contracted rate.)

-All fees must be paid at time of service including co-pays, deductibles, evaluation fees, out-of-pocket fees, etc.

-A returned check fee of $35 plus the amount of the original check will be charged for checks returned due to insufficient funds.

-Failure to resolve an outstanding balance in a timely manner may result in suspension of service until such time debt is paid.

*** Your credit/debit/health savings card will be charged $50 if you do not show up to your appointment or cancel within less than 24 hours notice.

-If an account should become delinquent, HOPE Behavioral Health has permission to charge the credit card on file for the patient's account for any amounts due. Also, the responsible party is aware that if payment cannot be obtained from this credit card and a new form of payment is not received, the account information will be turned over to collections and you will be responsible for the agency's collections fees as well as the outstanding balance.

-The patient, parent or guardian is responsible for notifying staff of a change of insurance as soon as possible or will otherwise be responsible for fees due to any lapse in coverage.

-24-hour advance notification is required for cancelling an appointment regardless if you receive the complimentary text or email reminder.

-We understand that situations arise that the patient or family cannot predict or control, however we offer TeleHealth and may be able to reschedule within the same day or week to support you in not having a no-show or late-canceled session. However, missed appointments result in lost time and income to the practice, regardless of reason or occurrence so the following policy applies:
***Three no-shows or late cancellations may result in suspension or termination of services.

By signing this form, you are signing that you have read and agree to these policies and are aware that if you do not follow these policies, you are opting out of treatment with HOPE Behavioral Health and its staff.

Termination from Treatment Policy:
-As a patient, you have the right to terminate treatment at any time unless otherwise ordered by the Court.
-The providers of Hope Behavioral Health also reserve the right to terminate patients from our practice for any reason we deem to be appropriate and /or necessary including: Verbal abuse to the staff or other patients including but not limited to threatening, name-calling, and verbal aggression.
-Physical assault or threat of staff, patients, or property
-Refusal to follow essential treatment recommendations that could result to harm to yourself or others.
-Three no-shows or late cancellations.
-Other reasons deemed appropriate by HOPE Behavioral Health staff.

By signing this form, you are signing that you have read and agree to these policies and are aware that if you do not follow these policies, you are opting out of treatment with HOPE Behavioral Health and its staff.

Child Supervision Policy (for children of adult patients):
-Hope Behavioral Health, LLC, cannot accept responsibility for unattended children.
-Please make arrangements for proper supervision and be considerate of other patients in the waiting room.

By signing this form, you are signing that you have read and agree to all of these policies above and are that you are aware that if you do not follow these policies, you are opting out of treatment and discharging yourself from our care at HOPE Behavioral Health.

Print Name_____Date_____

Relationship to patient_____

Signature_____

HOPE Behavioral Health
541 Buttermilk Pike Suite 200
Crescent Springs KY 41017
859-869-2023

Patient Name _____

Intake Questionnaire

Client Full Name:

Client Email:

Client Mobile Phone Number:

Client Date Of Birth:

Client/Patient's Address:

Are you open to seeing a Master's Level Intern under the supervision of a Senior Level Licensed Therapist?:

☐ Check if you are wanting Telehealth Appointments

☐ Check if you are wanting In-office appointments

What are the days and times you prefer to have appointments?:

How did you hear about us?:

Were you recently discharged from a psychiatric hospital?:

Are you, or will you be completing an Intensive Outpatient Program or Partial Hospitalization Program? (If so, when?):

Emergency Contact Name:

Emergency Contact Phone Number:

Street Address:

City, State, and Zip Code:

Race/Ethnicity of Client/Patient:

Place of Employment or School Attending: **Patient Name**

Name of Person Filling This Out and Relationship to Patient:

Are you currently seeing another therapist?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Why are you seeking therapy?:

Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Loss of Interest
- ☐ Panic Attacks
- ☐ Racing Thoughts
- ☐ Risky Activity
- ☐ Sleep Changes
- ☐ Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Patient Name _____

Allergies:

What medications are you currently taking?:

Previous diagnoses/mental health treatment:

Previously treated by:

Please provide your Primary Doctor's Name and Phone Number Below:

Previous medications:

Dates treated:

Previous medical conditions:

Please describe any developmental delays below:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental health conditions:

Were your family member's mental health conditions treated with medication and if so, which medications?:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

If you choose to disclose, what is your sexual orientation?:

If you choose to disclose, what is your gender identity?:

If you choose to disclose, what are your preferred pronouns?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

Patient Name _____

(check all that apply)

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuanna
- ☐ Hallucinogens (LSD)
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (Pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Are you currently in school?:

Legal history?:

Do you have a history of any of the following?

- ☐ I have had an eating disorder.
- ☐ I have been a victim of domestic violence.

- [ ] I have had suicidal thoughts.
- [ ] I have had homicidal thoughts.
- [ ] I have been a victim of child abuse.

Additional

Anything else you want the therapist to know or that was not covered on this form?:

HOPE Behavioral Health

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Patient Name _____

Telehealth Treatment Consent

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session. **I hereby give my consent for my therapist to use telehealth in my mental health treatment.**

Sign Here _____ **Date** _____ **11**

HOPE Behavioral Health
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859-869-2023

Consent to Bill Insurance

Patient Name:

Patient Date of Birth:

Insurance Company Name:

Insurance Member ID:

Insurance Group Number:

Subscriber Name (Who carries the insurance?):

Subscriber Date of Birth:

Insurance Provider Phone Number (on back of card):

Patient Name _____

Sign Here _____ **Date** _____

HOPE Behavioral Health
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Crescent Springs KY 41017
859-869-2023

Credit / Debit/ HSA/ Flex Spending Card Payment Consent Form

Patient Name:

(Card holder) Name on card if different than patient:

Card Type (Visa, Mastercard, American Express, Discover, etc.:

Card Number:

CVV (on back of card):

Expiration Date:

Billing Zip Code for Card:

I authorize HOPE Behavioral Health to charge my credit/debit/health account card for the patient responsibility amount due for professional services and I authorize HOPE Behavioral Health to charge my credit/debit/health savings card $50 if I do not show up to my appointment or cancel within less than 24 hours notice.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Print Name_____Date_____

Signature_____

HOPE Behavioral Health

541 Buttermilk Pike Suite 200
Crescent Springs KY 41017
859-869-2023

Master's Level Student Intern Consent Form

Master's Level Student Intern

Informed Consent for Treatment

☐ Check if you do NOT consent to receiving therapy services from a Master's Level Intern under the Supervision of a Senior Level Licensed Therapist.

☐ Check if you DO consent to receiving therapy services from a Master's Level Intern under the Supervision of a Senior Level Licensed Therapist.

I understand that my child, my family, or myself will be receiving therapy services from a Master's level student intern who is under the supervision of Hope Behavioral Health, LLC, a member of the Social Work program at a university in Kentucky and the Field Placement Office of their educational institution. The Master's level intern I or my family member(s) will be seeing for treatment services is supervised at Hope Behavioral Health, LLC, by a Senior Level Licensed Therapist, as well as the acting supervisor for their educational institution.

I understand that student interns are bound by the ethical guidelines of their profession and adhere to the guidelines specified by the Hope Behavioral Health, LLC services agreement, Telehealth Service Consent, Internship Supervision Agreement of their educational institution and Notice of Privacy Practices / HIPAA.

I understand that student interns have completed most Master's level education from their educational institution in their field of study, have demonstrated core competencies and have been determined by their educational institution as ready to apply his or her clinical skills to working with clients.

I understand that student interns receive intensive ongoing guidance, evaluation, and education in providing excellence in clinical skills to you and your family members. By working with a student intern, each client receives the benefit of a clinically experienced supervision team assisting in assessment and treatment planning to address concerns in therapy.

I understand that student interns may provide counseling sessions in conjunction with a fully licensed clinician, and when deemed ready by Hope Behavioral Health, LLC, will provide counseling sessions without a supervising clinician present.

I, the client or his/her/their legal, custodial parent, or legal guardian, acknowledge that I am voluntarily authorizing treatment for myself or my child/ward at Hope Behavioral Health, LLC, by a Master's Level Student Intern. I have been informed that this is my choice and I am able to choose other options for treatment.

Name_____

Sign Here_____ Date_____

Hope Behavioral Health
541 Buttermilk Pike Suite 200
Crescent Springs, KY 41017
Phone: 859-869-2023 Fax: 561-401-9196

Patient Name: _____ **Patient DOB:** _____

I authorize _Hope Behavioral Health NKY_ to receive from and/or disclose information to the following:

1. ☐ Receive from and/or ☐Disclose _____

   Phone: _____ Fax: _____

   Address: _____

2. ☐ Receive from and/or ☐Disclose _____

   Phone: _____ Fax: _____

   Address: _____

3. ☐ Receive from and/or ☐Disclose _____

   Phone: _____ Fax: _____

   Address: _____

The following information may be disclosed: (check all that apply). ☐Diagnostic impressions; ☐Written report, if available; ☐ Recommendations; ☐Progress; ☐Additional information

_____

Purpose of receiving or disclosing information is to: (check all that apply). ☐Assist with testing; ☐Assist with therapeutic needs; ☐ Provide evaluation for court proceedings or possible legal proceedings; ☐Pre-employment evaluation; ☐Additional information

_____

The information may be released in the following form: ☐Written; ☐Verbal; ☐Fax; ☐E-mail; ☐Conference or Observation; ☐Video or Audio Tape

I understand that my rights are protected under federal regulations governing confidentiality and that I may revoke this consent at any time except in writing to the extent that action has been take in reliance on it.

This release covers the duration of treatment otherwise stated: Expiration Date: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable) _____ Date: _____

TriHealth Corporate Health

TriHealth Employee Assistance Program
STATEMENT OF UNDERSTANDING
CLIENT'S RIGHTS AND RESPONSIBILITIES

What does TriHealth EAP provide?
TriHealth EAP provides counseling services at no cost to you. Specifically, TriHealth EAP provides assessment, short-term counseling when appropriate, referral when needed, and follow-up. When a problem requires specialized or longer-term services, a referral will be made following the assessment of your situation. If you are referred, there may be fees involved for the specialized or long-term services. Those services may be covered under the medical benefits plan provided by your employer; however, it is your responsibility to determine whether the services are covered by the plan.

What does a referral involve?
When a referral is advised, your counselor will work with you to find an appropriate resource. We find that it is in your best interest to make the referral at the earliest possible point so that you can start working immediately with the appropriate treatment provider. The referral usually takes place after the first or second session with the TriHealth EAP counselor.

Is TriHealth EAP counseling confidential?
No information regarding you or your problem can be released to anyone without your express written consent. If you request we contact someone on your behalf, you must complete an informed consent release. State and federal laws, however, mandate that in cases of child abuse, elderly abuse, or when a person may be a threat to his or someone else's safety, the counselor must notify the proper authorities. TriHealth EAP must also release records if ordered to do so by a court of law. TriHealth EAP complies with State and Federal Law including CFR42 and the Health Information Portability and Accountability Act (HIPAA).

What are the counselor's responsibilities?
Your counselor is responsible for defining the problems as fully as possible. This process is started by completing a general history. Through this assessment, the counselor will determine an approach to the problem, be it short-term counseling or a referral. Your counselor will provide you with honest information about the nature of your particular problems and recommend treatment alternatives based on what is most likely the best outcome. The final decision on what to do is up to you.

What are your responsibilities?
The counseling process is most likely to produce results if you are willing to look at your own behavior, are honest, and are willing to act on what is learned in counseling. You are responsible for setting and keeping appointments. **Please provide as much notice as possible if an appointment is going to be missed.** Generally, failure to notify is considered lack of involvement in the counseling process.

Our goal is a positive, helpful experience for you at TriHealth EAP. Feel free to discuss any problems or concerns you have with the counselor or to call 1-800-642-9794. We value your confidence in us and your suggestions to improve our services.

I have read this form, understand its contents, and understand that the affiliate counselor will inform the 800 number counselor of their assessment and recommendations for my treatment.

Signature of Client	Date	Witness	Date

Clearly print name of client: _____

Return To: *TriHealth EAP Affiliate Services*
Mail: 4665 Cornell Rd., STE 350 Cincinnati, OH 45241
Email: corporatehealthbilling@trihealth.com
Fax: 513-852-3058