



PJ Mercer & Associates, LLC
Priscilla Jones Mercer, LCSW-C, LCADAS, SAP
66 Painters Mill Road, Suite 204
Owings Mills, MD 21117
(O) 667-303-3204 (F) 667-303-3560

EAP Client Packet

Client Name: _____

Date of Birth: _____

SSN: _____

Race African American Caucasian Hispanic Other Ethnic Preference _____

Address _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Person: _____ Relationship _____

Phone Number: _____

Insurance Carrier: _____

Insurance Policy Number: _____

Client Signature: _____

_Date: _____



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EAP Affiliates and Staff: Please offer to read the following statement to EAP participants and discuss the content with them, providing any additional assistance required to review and understand this document particularly for individuals with special needs.

EMPLOYEE ASSISTANCE PROGRAM
EAP PARTICIPANT STATEMENT OF UNDERSTANDING

To Our EAP Participants:

PJ Mercer & Associates, LLC is pleased that you have decided to use your Employee Assistance Program (“EAP”). The EAP is a voluntary service available to eligible employees and family members. There are several things we want you to know before we begin discussing your reason for contacting the EAP.

Personal problems are sometime very difficult to talk about. That is why confidentiality is extremely important to us. We take every precaution in protecting the confidentiality of your visit with us and we hope that you will do the same. A written and electronic record (date, time, nature of meeting) of your contacts with the EAP will be maintained in a secure manner. Access to the record will not be given to anyone outside of the EAP, except as required by law or as described below. To access your file, contact PJ Mercer & Associates, LLC.

This provides an opportunity for you to discuss personal problems with us. We will help you with an assessment of your personal problems and then develop a plan of action with you. The plan of action may include a referral to an appropriate resource to help you resolve your problems. After the referral is made, we will follow up to be sure the referral is satisfactory. In the event that there is no referral, we will develop a plan of action for you.

Lawful release of records is permitted under the following conditions: if we learn about a child, elder or, disabled adult abuse or neglect, if you pose a threat of imminent danger to yourself or others, if we are required to present records to comply with a court order, to comply with other state and federal requirements, and if we learn about any emergency medical circumstances which require immediate medical attention.

To the extent possible, we want to ensure the counselor that you will be meeting with is a person with whom you are comfortable. For example, some people have a preference for a counselor of a particular gender, sexual orientation, ethnicity, or religion. If this a concern, PJ Mercer & Associates, LLC would like to give you the opportunity to let us know so that we may attempt to arrange a referral to a counselor that is appropriate for you. Should you have any questions or concerns or be dissatisfied with the EAP or your counselor, please contact PJ Mercer & Associates, LLC.

This is no cost to you for any EAP services provided by PJ Mercer & Associates, LLC. The Employee Assistance Program does not, however, cover the costs of therapy or community resources/treatment services to which you may be referred. We attempt to maintain up-to-date information on your health insurance coverage so that we can refer you to providers covered by your plan. However, it is your responsibility to verify that your insurance will cover the cost of such therapy or other treatment resources.



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I hereby acknowledge that I have read and understand this Statement of Understanding.

_____	_____	_____
Participant Name (Please Print)	Participant Signature	Date
_____	_____	_____
Personal Representative Name (Please Print)	Personal Representative Signature	Date

If you are signing this form on behalf of someone other than yourself, please enclose with this form proof of your authority to do so an attach written documentation (i.e. Guardianship Order, Custody Order, Court Order) as appropriate.



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Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.

- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.

- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.

- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all the time.

6.

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.

- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.



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- 8.
- 0 I don't feel I am any worse than anybody else.
 - 1 I am critical of myself for my weaknesses or mistakes.
 - 2 I blame myself all the time for my faults.
 - 3 I blame myself for everything bad that happens.
- 9.
- 0 I don't have any thoughts of killing myself.
 - 1 I have thoughts of killing myself, but I would not carry them out.
 - 2 I would like to kill myself.
 - 3 I would kill myself if I had the chance.
- 10.
- 0 I don't cry any more than usual.
 - 1 I cry more now than I used to.
 - 2 I cry all the time now.
 - 3 I used to be able to cry, but now I can't cry even though I want to.
- 11.
- 0 I am no more irritated by things than I ever was.
 - 1 I am slightly more irritated now than usual.
 - 2 I am quite annoyed or irritated a good deal of the time.
 - 3 I feel irritated all the time.
- 12.
- 0 I have not lost interest in other people.
 - 1 I am less interested in other people than I used to be.
 - 2 I have lost most of my interest in other people.
 - 3 I have lost all of my interest in other people.
- 13.
- 0 I make decisions about as well as I ever could.
 - 1 I put off making decisions more than I used to.
 - 2 I have greater difficulty in making decisions more than I used to.
 - 3 I can't make decisions at all anymore.
- 14.
- 0 I don't feel that I look any worse than I used to.
 - 1 I am worried that I am looking old or unattractive.
 - 2 I feel there are permanent changes in my appearance that make me look unattractive
 - 3 I believe that I look ugly.



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- 15.
- 0 I can work about as well as before.
 - 1 It takes an extra effort to get started at doing something.
 - 2 I have to push myself very hard to do anything.
 - 3 I can't do any work at all.
- 16.
- 0 I can sleep as well as usual.
 - 1 I don't sleep as well as I used to.
 - 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 - 3 I wake up several hours earlier than I used to and cannot get back to sleep.
- 17.
- 0 I don't get more tired than usual.
 - 1 I get tired more easily than I used to.
 - 2 I get tired from doing almost anything.
 - 3 I am too tired to do anything.
- 18.
- 0 My appetite is no worse than usual.
 - 1 My appetite is not as good as it used to be.
 - 2 My appetite is much worse now.
 - 3 I have no appetite at all anymore.
- 19.
- 0 I haven't lost much weight, if any, lately.
 - 1 I have lost more than five pounds.
 - 2 I have lost more than ten pounds.
 - 3 I have lost more than fifteen pounds.
- 20.
- 0 I am no more worried about my health than usual.
 - 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
 - 2 I am very worried about physical problems and it's hard to think of much else.
 - 3 I am so worried about my physical problems that I cannot think of anything else.



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INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three.

This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question.

You can evaluate your depression according to the Table below.

Enter Total Score Here: _____

Levels of Depression:

1-10 _____ These ups and downs are considered normal

11-16 _____ Mild mood disturbance

17-20 _____ Borderline clinical depression

21-30 _____ Moderate depression

31-40 _____ Severe depression

over 40 _____ Extreme depression

A PERSISTENT SCORE OF 17 OR ABOVE INDICATES THAT YOU MAY NEED MEDICAL TREATMENT



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Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone:

FREE CONFIDENTIAL SUPPORT

**The National Suicide Prevention Hotline (24/7) 1-800-273-8255

**Baltimore Crisis Response Inc. (24/7) 410-576-5097

**Baltimore Crisis Response Inc. (Mobile Crisis Team) (24/7) 410-433-5175

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of Client/Parent/Legal Guardian

Date

Signature of Therapist

Date



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Telemental Health Informed Consent

I _____, (**name of client**) hereby consent to participate in Telemental health with Priscilla Jones-Mercer, LCSW-C (**name of provider**) as part of my psychotherapy.

I understand that Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. PJ Mercer & Associates is located in the state of Maryland, which is in the Eastern Standard Time (EST) zone, in the Unites States of America.

I understand the following with respect to Telemental health:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risk and consequences associated with Telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telemental health services are not appropriate, and a higher level of care is required.
- 6) I understand that during a Telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at (667) 303 - 3204 to discuss since we may have to reschedule.
- 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.



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Statement of Understanding
 FOR THE RELEASE AND EXCHANGE OF INFORMATION

I, _____ acknowledge that Priscilla Jones-Mercer
 (Name of Employee) (Name of SAP)
 and the entities named below must disclose to each other and receive from each other pertinent and relevant information regarding:

1. Violation of DOT regulation
2. Drug and/or alcohol test results
3. Summary of the treatment plan
4. Evaluation and treatment recommendations
5. Treatment progress reports, including attendance and test results
6. Program completion information, including discharge summary
7. Other relevant information as it pertains to return-to-duty process

EAP	_____	_____	_____
	(Name)	(Employee's Signature)	(Date)
Treatment Program	_____	_____	_____
	(Name)	(Employee's Signature)	(Date)
DER	_____	_____	_____
	(Name)	(Employee's Signature)	(Date)
MRO	_____	_____	_____
	(Name)	(Employee's Signature)	(Date)
Other	_____	_____	_____
	(Name)	(Employee's Signature)	(Date)

The Purpose of the exchange of this information is to comply with DOT requirements that must be met before I make take a Return to Duty drug and/or alcohol test, prior to being considered by my employer for returning to the performance of safety-sensitive functions under DOT regulations.

I understand that communication between service agents/entities is required under U.S. Department of Transportation rules and regulations and is permitted without my authorization. In addition, the regulations permit the SAP to send required reports to my employer, without my authorization. However, in order for the SAP to provide reports to employers other than my current employer, including future employers, the SAP must obtain my written authorization.

I understand that my written consent will be obtained prior to disclosing information to any entity other than those listed herein.