FORM TO BE FAXED AFTER ASSESSMENT IS COMPLETED

HelpNet

Phone: 1-800-969-6162
FAX: 1-269-245-3899
or 1-269-245-3890

AFFILIATE CLIENT RELEASE AUTHORIZATION

☐Job Jeopardy ☐Formal Management Referral ☐EAP Voluntary

Client Name:	Contracted Company:
Date of Birth:	Confidential Phone:

By signing this form, I give my permission for HelpNet EAP to obtain and/or release my protected health information to and from the individuals(s) listed below, only under the conditions marked:

Affiliate Provider Name:	Confidential Phone:
Secure Email:	Confidential Fax:

Information authorized to disclose:

☐ Assessment ☐ Client Status ☐ Progress
☐ Attendance ☐ Prognosis ☐ Diagnosis
☐ Referral/Recommendations ☐ Testing Results ☐Other (Please specify):
☐ Alcohol and drug abuse (treatment information is protected under the regulations in CFR 42, Part 2)

I authorize the release of any medical information (optional), *if* contained in my medical record, which may include:

☐ HIV/AIDS related information
☐ Information regarding communicable diseases/infections as defined by statute and Michigan Department of Health

The purpose of this disclosure:

Coordination of Services for: ☐Job Jeopardy/FMR Case Management ☐EAP Voluntary ☐ Other:

Acknowledgement of Understanding

- This patient consent form is in accordance with all state and federal guidelines.
- A photocopy or fax of this signed consent form shall have the same force and effect as the client's original signature.
- I may withdraw this authorization at any time with written notice. Revocation of this authorization will not affect any information already released. This authorization shall expire without expressed revocation one year (12 months) from the date written below.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness/Provider Date

_____
Printed Witness Name & Relationship to Client

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HelpNet

EAP PARTICIPANT STATEMENT OF UNDERSTANDING

HelpNet Employee Assistance Program is pleased that you have chosen to use your EAP benefit. These services are offered to employees of contracted companies and their household family members, and may include assessment, brief counseling, and/or a referral by Master's level Counselors in social work, psychology, counseling, or other related fields.

EAP counseling is voluntary. Your employer has paid for their employees with personal and/or work problems to meet with a counselor for a limited number of sessions. We provide counseling for a variety of issues that affect mental and emotional well-being, such as work-life balance, alcohol and other substance abuse, stress, grief, family problems, and psychological disorders. If we are unable to help you with your counseling needs, your therapist may refer you to a community resource or treatment agency. In some cases, our EAP Counselors may be able to provide longer-term outpatient services using your health insurance or private pay option. If we refer you, we will also give you other referrals to choose from, based on your preferences, insurance, and your ability to pay for continued treatment.

Confidentiality is very important to us. You are protected by the Health Insurance and Portability Act (HIPAA), which requires us to keep your health information confidential. We follow all state and federal requirements. We maintain secure written and/or electronic records of your contact with us and we will not share this information with anyone outside of our EAP staff without your written permission. Exceptions are as follows, as required by law in which we are required to report to the proper agencies: court order, or subpoena, indication of serious harm to self or others, abuse or neglect of child, elderly or disabled adult, and/or serious emergency medical issues requiring immediate medical care.

Federal law states we cannot disclose any information that identifies the client as an alcohol or drug abuser or HIV/AIDS information, unless: the employee consents in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Medical/Clinical records are confidential clinical documentation by HelpNet Counselors. You have the right to request a copy of your medical record with signed written authorization. You must obtain documents from outside agencies from the original source.

Formal referrals occur when your supervisor/manager refer an employee for a work performance problem. If your supervisor makes a formal referral, your counselor may be required to disclose your compliance with treatment recommendations with your supervisor, including alcohol or drug policy violations. Any of these disclosures will require your written authorization.

Quality service is important to us. If, at any time, during your participation with the EAP you have concerns about your counseling services, you are encouraged to discuss it with your therapist. If you are unable to reach your therapist or have spoken to your therapist and still dissatisfied, you are encouraged to contact HelpNet's Manager of Business Operations at (269)245-3928.

☐ I read and understand this Statement of Understanding.
☐ I received my Recipient Rights and Notice of Privacy Practices.
☐ I consent to assessment and treatment for mental health and/or substance abuse issues.
☐ I give HelpNet permission to follow-up with me regarding how I am doing, and my satisfaction with services.

Client Name (Print)	Client Signature	Date
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
EAP Counselor or Witness Name (Print)	Signature	Date

Battle Creek
36 W. Manchester
Battle Creek, MI 49037
PH: 269.245.3900
PH: 800.969.6162

Kalamazoo
5400 Holiday Terrace, Suite 9
Kalamazoo, MI 49009
PH: 269.372.4500
PH: 800.523.0591

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CLINICAL ASSESSMENT FORM & DISCHARGE SUMMARY

(Please completely fill out and fax to HelpNet after completion of assessment & final session)

Name of Client: DOB: Employer:

Provider/Agency Therapist:

Billing Address:

Date of Initial Appointment: Additional Appointment Dates:

Brief Clinical Assessment:

Are there any risk factors?

- ☐ Suicide
- ☐ Homicide
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Domestic Violence
- ☐ Other:

RECOMMENDATIONS:

- ☐ Brief EAP Counseling
- ☐ IOP/Outpatient Chemical Dependency Treatment
- ☐ No Referral
- ☐ Outpatient Psychotherapy
- ☐ Inpatient Psychiatric
- ☐ Support Group
- ☐ Referral
- ☐ Partial Hospital Program
- ☐ Residential Chemical Dependency Treatment/Detox
- ☐ Other:

DISCHARGE SUMMARY

Total Number of Sessions: Date of Last Session: ☐ Client Informed of SurveyMonkey link to survey

Progress Toward Goals:

Discharge Recommendations:

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REQUEST FOR ADDITIONAL SESSIONS

Name of Client: DOB: Employer:

Provider/Agency Therapist:

REQUEST FOR ADDITIONAL SESSIONS

Does the clinical assessment suggest treatment can be completed within the Solution-Focused Brief Therapy Model? Y☐ N☐

Number of additional EAP sessions you are requesting? ___

Is the client aware of the limitations of EAP and aware of other treatment options? Y☐ N☐

TREATMENT PLAN:

ADDITIONAL COMMENTS:

Provider's Phone Number: Provider's FAX Number:

RESPONSE TO AFFILIATE:

Additional sessions authorized (please indicate none or number of sessions): _____

ADDITIONAL COMMENTS:

HelpNet Approval Date

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AFFILIATE PROVIDER INVOICE FORM

INSTRUCTIONS: Complete the billing portion and return to **HelpNet**, ATTN: Marcy Bonney, at 36 W. Manchester, Battle Creek, MI 49037 or FAX to 269-245-3890 with the following forms: **Release of Affiliate Client Information**
Clinical Assessment
EAP Statement of Understanding
Request for Additional Sessions
Discharge Summary

Client Name: DOB:

Contracted Company: Date:

NOTE: Final payment will not be paid without receipt of Discharge Summary

Session Number	Interim or Final	Date of Service	Amount of Invoice
	☐ Interim ☐ Final		
	☐ Interim ☐ Final		
	☐ Interim ☐ Final		
	☐ Interim ☐ Final		
	☐ Interim ☐ Final		

Affiliate Provider/Agency: Phone No:

Please Make Check
Payable To (MUST MATCH W-9):

HelpNet is not responsible for the cost of any sessions provided without prior authorization.
Invoice must be submitted within 30 days of the service provided to be considered for payment