



CONTACT

**CONTACT
EAP CLIENT INFORMATION
FORM**

**SABHA/CONTACT
P.O. Box 60968
Phoenix, AZ 85082-0968
800-888-1477
(602) 659-1977**

Social Security No. _____ Marital Status _____ Date _____
Name _____ Date of Birth _____ Age _____
Address _____ (1) Male ___ (2) Female ___
City _____ State _____ Zip _____
Home Telephone () _____ Work Telephone () _____ Other () _____

Identify yourself as (1) Employee with Employee Assistance Program (EAP) benefit _____ OR (2) Dependent _____
If dependent, your relationship to employee _____

In case of emergency, please notify:
Name _____ Telephone () _____ Relationship _____

The following is information about the Employee with the EAP benefit. (Employee gives information about self; dependent gives information about the covered employee.)

Name of Employee _____ Social Security No. _____
Address _____ City _____ State _____ Zip _____
Home Telephone: () _____ Work Telephone:() _____ Date of Birth _____
Employer _____ Full-time _____ Part-time _____
Job Title _____ Work location/district _____
Division _____ Department _____
Employment Start Date _____ (1) Male _____ (2) Female _____

- Please circle the appropriate number for each of the following categories (for statistical purposes only – optional).
- RACE: (1) American Indian or Alaskan Native (2) Asian or Pacific Islander (3) Black
(4) Hispanic (5) White
- EDUCATION: (1) No high school (2) Some high school (3) High school diploma
(4) Some college/technical training (5) Bachelor's degree (6) Master's degree (7) Doctoral degree
- IF SCHOOL DISTRICT: (1) Certified (2) Classified
- CLASSIFICATION: (1) Management (exempt) (2) Non-management (non-exempt)
- REFERRED BY: (1) Self (2) Supervisor (3) Co-Worker (4) Relative (5) Personnel (6) Nurse/Doctor
(7) Other _____ (8) Internal EAP

FOR COUNSELOR'S USE ONLY COUNSELOR'S NAME (print) _____
Provider's Tax ID # _____ EAP CO. CODE _____

Part A New Client
Client's Name _____ Date _____ DSM _____

Session Code: (circle one) INDIV = Individual Therapy TELPH = Telephone Call NOSHW = No Show FAMHD = Family Visit (please complete Part B)
Presenting Problem Code: (circle one) M=Marital CD=Chemical Dependency R=Relational F=Family W=Work I=Individual

Part B – Other Attendees	Date of Birth	Relationship to Employee	
Name (first, last) _____	_____	_____	FAMDE=Family Visit: Dependent
_____	_____	_____	FAMDE=Family Visit: Dependent
_____	_____	_____	FAMDE=Family Visit: Dependent
_____	_____	_____	FAMDE=Family Visit: Dependent

REFERRED TO (circle one): CONTACT Provider Non-CONTACT Provider REFERRAL DATE: _____
REFERRED FOR (circle one): Mental Health/Psychiatric Chemical Dependency Medical Self-help Other



CONSENT FOR TREATMENT

I, _____, grant CONTACT permission to provide outpatient behavioral health services to me and/or _____ within the limits of the contract between my (or my spouse's) employer and _____
name of minor child

CONTACT. I understand that information given to CONTACT providers will not be shared with any source outside of CONTACT without my written permission, except where required by law (for example, danger to self or others or suspected child abuse). I acknowledge that I have been given a copy of an approved summary of Federal law and regulations regarding the confidentiality of alcohol and drug abuse patient records (Confidentiality Information Handout.) I have also been informed of my rights as a client of CONTACT (Statement of Rights and Roles of Members.) I understand that I may withdraw this consent at any time by notifying my CONTACT provider. I understand that CONTACT's Quality Assurance Program may require my provider to discuss my case with a CONTACT clinical supervisor. All providers will be bound by all confidentiality regulations and statutes.

I understand that the CONTACT provider may determine that additional or specialized treatment is clinically necessary and, if CONTACT does not provide that treatment, CONTACT will suggest appropriate alternatives. However, I am still free to choose my own treatment or not to seek further treatment. I understand that CONTACT will NOT be responsible for the cost of additional or alternative treatment.

I understand that all psychotherapy by the CONTACT provider will be verbal. CONTACT does provide limited psychiatric services under specific Managed Care contracts. I also understand that EAP services are a paid benefit via my employment (or my spouse's employment) and may be provided with no cost to me unless a specific co-pay is indicated below.

<p>AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION</p> <p>The following is a general authorization for the release of medical and other related information.</p> <p>I hereby authorize any physician, health care professional, hospital, clinic or other medical or medically related facility to furnish an agent, designee or representative of CONTACT, any and all records pertaining to medical history, services rendered or treatment given any one enrolled hereunder or added hereafter. CONTACT, or its agents, designees or representatives may disclose to a health care provider, health care service plan or insurer any such medical or mental health information obtained (including information regarding alcohol or drug abuse, or confidential communicable disease related information).</p> <p>The purpose for which such information may be disclosed include coordination of health care, utilization review, quality assurance, financial audit and claims processing.</p> <p>This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable CONTACT to perform the functions referred to in the preceding paragraph.</p>
--

Where may we call you*? Home Work Neither
Where may we leave a message*? Home Work Neither

***Please note that the CONTACT name will appear on caller ID display screens.**

Date

Client or Parent/Guardian

Date

Witness

FEE AGREEMENT

I understand that services provided by CONTACT may require a payment (co-pay) that is my responsibility, according to the provisions of my contract benefit.

Below is the fee schedule for which I am responsible at the time the services are rendered. I also understand that, dependent upon terms of my insurance contract, I may be responsible for a specified charge should I not attend my sessions without giving at least 24-hours notice. I understand that I will be notified within 30 days should fees change.

If it is determined that I am not eligible for benefits through CONTACT, I will be responsible for payment in full for services provided.

- EAP sessions at no cost
- Insurance benefits:
Co-payment of \$_____ per session
 - Graduated co-payment:
_____ sessions at \$_____
 - _____ sessions at \$_____
 - _____ sessions at \$_____
- Private counseling at \$_____ per session
(No EAP or insurance benefit at CONTACT)
- No co-pay for assessment on ____/____/____

Date

Client/Legal Guardian

Date

Witness

Confidential Pursuant to A.R.S. 36-2403

HAVE CLIENT COMPLETE FORM AT FIRST VISIT



CONTACT Member Rights and Roles

We at CONTACT respect your rights as a member and recognize you as an individual with unique behavioral health care needs. We respect your personal dignity and strive to provide you with high quality care and services which are responsive to you as an individual.

We expect and encourage you to be actively involved in utilizing our wide range of services to attain and sustain optimal good health. We also expect and encourage you to take responsibility for your health by adopting a healthy lifestyle that includes exercise, healthy eating habits and taking precautions such as wearing your seatbelt.

At CONTACT, we believe that the process of sustaining good health involves a partnership between our staff, your providers and you, the member. Consequently, we believe that each of us shares a role in assuring that your behavioral health needs are met. Because we value you as a member, we wish to share with you what you should expect from our role in that partnership. Similarly, we wish to suggest how you should view your role in actively participating in your health care. The following descriptions reflect CONTACT's commitment to its members and recommendations as to how you can best benefit from our services.

Your Rights

- To be treated with respect for your personal dignity and need for privacy – regardless of race, color, religion, sex, age, physical or mental handicap or national origin. All provider offices actively take steps to ensure member privacy.
- To expect CONTACT to provide, arrange for, and coordinate your behavioral health care services.
- To participate in decisions involving your behavioral health care (or in the behavioral health care of dependents) and to be informed regarding your behavioral health issues, treatment and prognosis in terms that you can understand.
- To be provided with information about your behavioral health benefits, participating providers, clinical management criteria, and your rights and responsibilities as a member.
- To reasonable access to behavioral healthcare services and information about charges for which you will be responsible.
- To express an inquiry/complaint or file an appeal and when doing so to be accorded respect and courtesy. The right to expect an answer to the complaint or appeal within a reasonable period of time. (To do so, call Member Services at 602-730-3023.)
- To provide CONTACT with feedback on the quality of care and services through member satisfaction surveys, conversations with Member Services representatives and written correspondence.

Your Roles

- To choose and establish a relationship with your CONTACT provider so that in the event of an urgent situation you will have someone who knows you and can assist you.
- To review your Certificate of Coverage so that you can appropriately utilize the services available to you.
- To participate in the development of your treatment plan and adhere to the treatment plan agreed to by yourself and your behavioral healthcare provider and to discuss any desired change or deviation from that treatment plan before personally making a change.
- To inform your providers of any changes that could influence your insurance coverage or treatment plan and to give accurate and complete information about your condition.
- To notify your employer in the event of a change in mailing address, telephone numbers, number of dependents or acquisition of other health insurance.
- To notify the provider's office at least 24 hours before you must cancel a scheduled appointment.
- To express opinions, concerns or complaints about CONTACT or the care provided to you in a constructive and appropriate manner within the system, including grievance procedures established by CONTACT.
- To make recommendations regarding CONTACT's Members' Rights and Roles policies.



CONTACT

CONTACT

CLIENT ORIENTATION FORM

CONTACT is an Employee Assistance Program provided by your employer as a service to its employees. CONTACT provides counseling services to all employees and their dependents. As an employee covered by the benefit, you and your dependents are entitled to a specific set of sessions per contract year (a copay may be required). Your counselor can give you more detailed information during your first visit. If longer term or special services are needed, CONTACT counselors will refer you to appropriate services. Any expenses incurred for treatment from these referral services will then be your responsibility. Your insurance, however, may pay for a portion of the expenses.

Except for cases of child abuse or danger to self or others, all information shared with CONTACT counselors is confidential. Your employer will not be informed of your visit nor will any information be shared. If you wish information shared with an outside service, you must sign an Authorization for Exchange of Information form.

CONTACT will not discharge or discriminate in any way against any client by whom, or on whose behalf, a complaint has been submitted to the Arizona Department of Health Services (1647 E. Morten, Suite 240, Phoenix, AZ, 85020, 674-4300) or who has participated in a complaint investigation process.

***** IMPORTANT INFORMATION *****

CONTACT requests a twenty-four hour advance notice if you need to change or cancel a scheduled appointment. Appointments which are not kept or not canceled in a timely manner WILL be counted as one of the sessions to which you are entitled. If you miss two appointments without canceling them, further counseling services at CONTACT may be denied. Unless you object, we will give you a reminder call the day before your appointment. In order to be fair to all those seeking counseling, only one appointment will be set up at a time, in most cases. If you have any questions regarding the services available to you, please feel free to discuss them with your counselor. Any complaints should be reported to our corporate office.

SUMMARY

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) The patient consents in writing, 2) The disclosure is allowed by a court order, or 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for federal regulations.)

Please keep a copy of this for your records.