wellspring

1900 Rainier Avenue South
Seattle, WA 98144

Case# _____

Authorization # _____

Provider Line: 866.470.2301
Provider Fax: 866.738.7073

Employee Assistance Program Consent Form

THIS BENEFIT WILL HELP YOU:

- Determine the nature of your presenting concern, and the impact on you and your job performance.
- Determine if further intervention is needed.
- Determine a plan of action to remedy your concerns.

APPOINTMENTS:

Your initial assessment appointment was coordinated through the Employee Assistance Program (EAP) of Wellspring. Subsequent appointments will be set with your therapist. If you fail to keep the initial appointment without notifying your therapist 24 hours in advance that missed session will be charged to your EAP benefit. Any missed appointments after the first scheduled appointment may be charged to you by your therapist at their usual and customary fee.

FEES:

The cost of this service is covered by your employer, if you are benefits eligible. You will not be asked to make any payment for the service (except as detailed in the Appointments section above). If you seek services per the recommendation of your therapist beyond the EAP benefit you will need to use your medical insurance, another third party payer, or cover the cost out of pocket. If your benefits eligibility changes you will be responsible for that portion not covered by your employer for EAP services.

CONCERNS:

If you have any concerns or complaints about your service please address the issue directly with your therapist. If the issue is not resolved to your satisfaction feel free to direct your concerns to us in writing or call Wellspring EAP at 1.800.553.7798.

CONFIDEN.TIALITY:

No information about you is released to anyone without verified authorization, except as required by law or court order. Please discuss with your therapist the legal statutes in your state of residence that govern the release of client information. By signing below I give permission to release my name(s), date(s) of service, and general problem categories to Wellspring Employee-e Assistance Program. I understand that this information will be used for billing and statistical purposes only. Further, I understand that the self-identifying information I provide will not be released to my employer. This release is valid for 90 days and may be revoked by me at any time.

CLIENT TO COMPLETE

Client's Printed Name:_____

Employer:_____

Client's Street Address: _____

City, State, Zip: _____

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Therapist's Printed Name·: _____

Therapist's Signature: _____ Date: _____