Solution Resources
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EAP LLC
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Insurance Client Information and Consent Form

Client's Last Name	First	M.I.	Social Security Number		Previous Names	
Street Address	City	State	Zip	Age	Birth Date	☐ Male ☐ Female
Phone CELL ☐ Home ☐ ( )	Messages Okay? Text ☐Yes ☐No Voice ☐Yes ☐No	Employer	Work Phone		Okay to call at work? ☐Yes ☐ No	

How were you referred to us?

A. Insurance Network Referral Listing
B. Personal Family/Friend Referral
C. Healthcare Professional Referral
D. Solution Resources Website
E. Psychology Today Website
F. Other Website _____
G. Continuation of EAP Benefit
H. Other _____

Client's Marital Status:

1. Married
2. Single
3. Divorced/Separated
4. Widowed
5. Cohabiting with Partner

Number of Children in Household:

Insurance Carrier

Emergency Contact
Name
Phone ( )

Relationship to Client

By signing below, you acknowledge the following:

1. You (the client) are aware of the nature of the treatment to be provided by the counselor and understand that no guarantee has been made as to the results that may be obtained. You voluntarily consent to the treatment.
2. You understand that treatment is governed by rules of confidentiality. However, state and federal laws may require the unauthorized disclosure of information as described in the counselor's Disclosure statement.
3. You have the right to refuse treatment now and in the future.
4. Your provider may review cases with peers without disclosing client names. All providers and consultants are obligated to follow the same strict codes of professional conduct and confidentiality as your counselor.
5. You may review the file kept about you by the counselor.
6. You have received, read and understood the following information
   - Confidentiality of information, guidelines including release of information for billing purposes
   - Counselor and/or Practice Disclosure Statement
7. With your signature, you authorize the release of information contained on this form, including a diagnosis, for billing purposes to your insurance company.
8. With your signature, you accept full responsibility for any charges incurred on your account that are not covered by your insurance, including, but not limited to, any co-pays, deductibles, and no-show and late cancellation fees (see box below).
9. You ☐ do ☐ do not give permission to be contacted for a follow-up client survey: by telephone ☐ at home, ☐ at work or at _____ (enter alternate phone number), or by letter at the address you entered above.

_____ _____
Client's Signature (Parent if Minor under age 13) Date

_____ _____
Signature of Person Financially Responsible Date

No Show and Late Cancellation Policy

We are committed to providing you with prompt and attentive service and make every effort to schedule a convenient time for you. Any appointment we have scheduled is reserved for you exclusively. If you need to reschedule for any reason, please give us **at least 24 hours' notice** so that we may offer the appointment time to someone else. No Shows and Late Cancellations with less than 24 hours notice are rarely available for other clients, nor can we bill your insurance for these sessions. We will, therefore, charge a No Show / Late Cancellation fee of $65. This fee represents less than one half of our normal hourly rate and we will collect payment prior to the next session unless other arrangements have been made. With your initial, you accept responsibility for applicable charges.

Initials _____ *I have read and understand this policy.*