Solution Resources EAP LLC
140 S Arthur St., Suite 660
Spokane WA 99202
509-535-4074
www.solutionresources.net

Client Information and Consent Form

Please complete both sides and sign and initial below!

Client's Last Name	First	M.I.	Previous Name	Birth date	☐ Male ☐ Female

Street Address	City	State	Zip	Name of Client's Employer

Primary Phone ☐ cell ( )	Text Messages Okay? ☐ Yes ☐ No	Work Phone ( )	Email Address: permission to use for contact: ☐ Yes ☐ No

If Client is not the employee with the EAP benefit, please provide beneficiary's name:	Employer providing EAP	Emergency Contact Name Phone ( ) Relationship to client:

By signing below, you (the client or Person Financially Responsible) acknowledge the following:

1. You are aware of the short-term nature of the treatment toward problem identification, resolution and referral to be provided by the EAP. You 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 Confidentiality of Information acknowledgement.
3. You have the right to refuse treatment now and in the future.
4. Solution Resources providers may review cases with peers. All providers and consultants are obligated to follow the same strict codes of professional conduct and confidentiality as the client's 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, the demographic data collected for statistical purposes on the attached sheet and your session dates to Solution Resources EAP for billing purposes
8. With your signature, you authorize the release of billing information (name, dates of service) contained in your file to independent auditors when such an audit is requested by the employer providing the EAP benefit. Confidential case notes will not be released to the auditors and auditors will not release names to the employer.

Sign

_____

Client's Signature Date

_____

Signature of Person Financially Responsible Date

Please complete reverse side!

Resources for intelligent solutions

No Show and Late Cancellation Policy

We are committed to providing you with prompt and attentive service. We make every effort to schedule a convenient time for you as quickly as possible. 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 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.

Initial _____ *I have read and understand the above policy.*

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The following categories and questions refer to the Client. All information collected is for statistical purposes only. No identifying information will be released without Client consent. Please circle the number

Client's Gender: 1. Male 2. Female

Client's Age: _____

Client's Marital Status:
1. Married since _____/_____
2. Single
3. Divorced/Separated (_____/_____)
4. Widowed
5. Cohabiting with Partner

How is the Client related to the Employee with the EAP benefit?
1. Employee (Self)
2. Child
3. Spouse
4. Other relative
5. Other

How long has the Client been in current job?
0. N/A (not employed, student)
1. less than 1 year
2. 1-5 years
3. 6-10 years
4. 11-15 years
5. 16-20 years
6. over 20 years

What is the Client's occupation?
1. Management/Administration
2. Professional/Technical/Teacher
3. Skilled Craft
4. Clerical
5. Laborer
6. Other (e.g., student)

Who referred the Client to the EAP?
1. Supervisor due to job related issues
2. Supervisor due to personal concern
3. Family Member
4. Medical Professional
5. Self
6. Union Representative
7. Peer or Coworker Other

Client's Level of Education:
1. Less than Gr. 12
2. H.S. Grad or GED
3. Some College
4. Business/Technical School
5. Bachelor Degree
6. Advanced Degree

Please check if Client
☐ had no prior contact with this EAP
☐ has previously seen one of our EAP counselors

Is the Client a Union Member?
☐ Yes ☐ No

Is the Client a Veteran?
☐ Yes ☐ No

Is the Client's job in jeopardy?
☐ Yes ☐ No

Rank in order of priority/importance one or two of the issues Client wants to discuss with counselor (Mark at least one or two in order of importance):
1. Emotional/psychological issues
2. A family member's alcohol/drug use
3. My alcohol/drug use
4. Marital or family problems
5. Physical or sexual abuse
6. Job related concerns
7. Career/Life direction
8. Legal issues
9. Job performance
10. Financial
11. Medical (incl. chronic pain)
12. Stress or Anger
13. Other _____

If applicable: Spouse's name: _____
Names and ages of children in Client household: