Employee Assistance Program
Student Assistance Program
Registration Form/Treatment Agreement

Today's date:

CLIENT INFORMATION

Client's Last name:	First:	Middle:		

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Gender: ❑ M ❑ F

Street Address:	Social Security No.:	Parent/Guardian Home/Cell/Work Phone: ( ) ( ) ( )

P.O Box:	City:	State:	ZIP Code:

EAP/SAP INFORMATION

Who carries the EAP/SAP benefit:	Who referred you:	Employer/School District:	School and Current Grade Level:

IF CLIENT IS A MINOR PLEASE PROVIDE PARENTS' INFORMATION

MOTHER'S INFORMATION

Name: (If different than above) Address:

Birth Date:

Social Security Number:

(If different than above) Home Phone: Cell Phone: Work Phone:

FATHER'S INFORMATION

Name: (If different than above) Address:

Birth Date:

Social Security Number:

(If different than above) Home Phone: Cell Phone: Work Phone:

Client's relationship to subscriber:	❑ Self	❑ Sibling	❑ Parent/Guardian	❑ Other

Name of insurance	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

❑ I do ❑ I do not consent to receive reminder calls prior to appointments.

If you do want a reminder call what number should we use? _____

Please read and sign the EAP/SAP Agreement on the back side of this registration.

The Employee Assistance Program(EAP) and The Student Assistance Program (SAP)– Des Moines, has been retained by your employer/school district to offer you confidential consultation at no charge.

We will provide up to the number of contracted sessions for counseling to those clients with problems that can be helped with short-term counseling. Those clients with problems that cannot be helped with short-term counseling or that require more than the session limit will be referred to a resource or counselor in the community. If we recommend further care with a community agency or counselor, the costs of those treatments will be your responsibility. It is your responsibility to check with your insurance company or benefits department to request a community provider list and to verify coverage.

It is the policy of the EAP/SAP Program that information regarding clients is kept strictly confidential. We will not disclose any information unless disclosure is authorized by the client or is required by law, subpoena or court order. Legal requirements mandate the EAP/SAP staff to report life-threatening circumstances, including danger to yourself or others, child abuse, and dependent adult abuse.

Many clients question what information will be passed on to their employer.

1. If you have made this appointment on your own, no identifiable information will be passed on to your employer/school district without your written consent.
2. If your employer/school district official has required you to make an appointment you will be asked to sign a Release of Information form or you will be given a letter to take back to your employer/school district official with regard to your attendance.

No further information will be disclosed without your providing the EAP/SAP with your signed consent. Federal Regulations do not protect from disclosure information related to the commission of a crime against property or personnel by the client.

If a client is a minor child: I give permission for my minor child to receive EAP/SAP services from the Employee Assistance Program/ Student Assistance Program. I certify that I am the legal parent/guardian of the minor child with the legal authority to give such permission.

I have received a Patient Rights and Responsibility brochure and a HIPAA brochure with Notice of Privacy Practices.

I UNDERSTAND THAT IF I MISS AN APPOINTMENT AND HAVE NOT CALLED TO CANCEL SAID APPOINTMENT WITHIN 24 HOURS IT WILL BE SUBTRACTED FROM MY TOTAL NUMBER OF AVAILABLE SAP SESSIONS.

I have read, understand, and agree to the terms of this form.

_____

Signature of Client/Parent/Guardian

_____

Date

_____

Witness

This information has been disclosed to you from records Protected by Federal, confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person who it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rule restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.