CONSENT FOR SERVICES

Voluntary
I voluntarily consent for screening, assessment, brief counseling with the County of Santa Clara Employee Assistance Program (EAP). I understand that I am entitled to 7 sessions per calendar year with the EAP. I understand that appointments must be scheduled in advance and that if I want to reschedule or cancel, I must call 24 hours prior to my appointment time. If I do not show up and have not cancelled, the “no show” will count as one of my 7 sessions.

Confidentiality
I understand that California Civil Code, Section 56, and Federal Law (Title 42 Code of Federal Regulations, Part 2 and Health Insurance Portability and Accountability Act of 1996 – “HIPAA”) requires that information disclosed to the Employee Assistance Program (EAP) is confidential; it can only be released with the client’s written permission, a court order, or in accordance with the law. On occasion, your EAP counselor may need to communicate with you by electronic means. Any emails sent will be sent secure/encrypted.

I understand that California State Law requires that Licensed Marriage & Family Therapists break confidentiality in specific instances:

California Evidence Code 1024 states that a therapist (a.k.a. counselor) may break confidentiality “...if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”

Additionally, in accordance with California Law, I understand that if my EAP counselor has reasonable suspicion about child abuse, elder abuse and/or disabled or dependent adult abuse the counselor is required by law to report to the appropriate agency. Therefore, if in the course of my work with the EAP counselor I reveal such information, it will be reported to the appropriate protective agency and/or authorities.

Further, I understand that under Section 215 of the Patriot Act if an FBI agent presents a national security letter compelling a therapist’s compliance with the Patriot Act, the therapist must provide FBI agents with any items that are requested. The therapist is prohibited from disclosing to the patient or anyone else (who could reasonably inform the patient) that the subpoenaed items were either sought or obtained.

Client Initials ________
Coordination of Care

I understand that if I am under the care of a physician, health provider and/or another therapist, I will need to discuss this with my EAP counselor (therapist). To provide coordinated care, a written Release of Information is required to allow the EAP counselor to talk to my other health care provider(s).

Emergencies

I understand that while I am receiving services from the EAP, if I have a mental health or substance abuse emergency, I can during normal EAP business hours (M-F 8:00 – 6:30) contact my EAP counselor at (408) 241-7772. If unable to reach the EAP or if I do not desire to do so, I will go to my nearest hospital emergency room to seek care and services or call Suicide Prevention 1 (855) 278-4204.

Scope and Quality of Services

I understand that getting the most out of EAP services requires that I fully participate and promptly communicate any concerns about the quality of services to my EAP Counselor who will be glad to discuss it with me. The County has arranged to provide, at no cost to you, assessment, brief counseling and referral and/or follow-up/consultation services.

We do not offer long term treatment or therapy.

After assessment, typically one to 7 visits, an outside referral may be made. If an outside referral is made, you are responsible for any cost incurred. **Important:** EAP does not provide psychological evaluations, fitness for duty, workers compensation, or custody evaluation nor any court-mandated services. Please inform your EAP counselor at your first session of any involvement in legal proceedings relevant to your EAP participation.

Cancellation Policy

EAP requires 24 hour notice to cancel and reschedule visits. If not canceled, it will count as one visit.

Consent

*Your signature below indicates that you have read this Consent and understand it. If you have any concerns or questions you would like addressed before signing this Consent, please inform your EAP counselor.*

*NOTE: Telecounseling Clients may provide written or verbal consent.*

I have read and agree to the terms of this Consent for Services:

Client’s Signature ___________________________ Date ___________________________

Counselor Signature ___________________________ Date ___________________________