Solution Resources EAP LLC
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Private Pay Client Information and Consent Form

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

Referral Source:

A. Insurance Network Referral Listing [12]
B. Personal Family/Friend Referral [11]
C. Healthcare Professional Referral [4]
D. Solution Resources Website [13]
E. Psychology Today Website [9]
F. Other Website ____________________ [14]
G. Continuation of EAP Benefit [10]
H. Other __________________________ [8]

Client's Marital Status:

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

Number of Children Living in Household:

Insurance Carrier

Emergency Contact Name

Emergency Contact's 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 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, 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.
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 14) Date

_______________________________________ _______________________________
Signature of Person Financially Responsible Date

No Show and Late Cancellation Policy

At Solution Resources EAP, we are committed to providing you with prompt and attentive service. We make every effort to schedule a convenient time for you and as promptly 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 your insurance for these sessions. We will, therefore, charge a No Show / Late Cancellation fee of $50. 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.

Initials __________ *I have read and understand the above policy.*