

Dear Associate,

Thank you for agreeing to provide services on our behalf. The following pages contain documents required for our files.

Please have the client(s) complete the "EAP Intake Information" form. Each individual must also be provided with the **Statement of Understanding - Employee Assistance Services** and **Notice of Privacy Practices - H&H Health Associates, Inc.** included in this packet. The client will acknowledge receipt of these policies with their initials on the "EAP Intake Information" form.

The "EAP Clinical Discharge Summary" page is to be filled out by you, with the exception of the **Personal Assessment**. (This section was originally completed by the client on the "EAP Intake Information" page and is designed to measure their perception of progress or lack thereof).

The "Client Satisfaction Survey" form is to be presented to the client at the first session (in the event that this is the only contact). Please ask them to confidentially provide us with feedback according to the directions on that page.

Finally, for fast payment processing, we ask that you record session activity on the "Authorization of Service" page you should have received from us and return this with any progress notes, the "EAP Intake Information" and "EAP Clinical Discharge Summary" forms.

Thank you again. Please feel free to contact us with any questions or comments.

H&H Health Associates, Inc.  
11132 South Towne Square  
Suite 107  
St. Louis, MO 63123  
Attention: Intake Department  
314.845.8302 / 800.832.8302  
314.845.8087 – Fax  
[info@hhhealthassociates.com](mailto:info@hhhealthassociates.com)

### EAP INTAKE INFORMATION

Today's Date: \_\_\_\_\_

#### CLIENT INFORMATION

Last name	First name	Middle

**EAP Services are available to me through:**

My employer <input type="checkbox"/>	Spouse's employer <input type="checkbox"/>	I am a dependant <input type="checkbox"/>
Other <input type="checkbox"/> Explain:	Company name:	

I acknowledge that a "Statement of Understanding-Employee Assistance Services" was provided to me and any questions I had were answered to my satisfaction.	<input type="checkbox"/> initial
I acknowledge that a "Notice of Privacy Practices H&H Health Associates, Inc." (HIPAA Policy) was provided to me and any questions I had were answered to my satisfaction.	<input type="checkbox"/> initial

#### GENERAL BACKGROUND

What brings you to the EAP today? \_\_\_\_\_

#### PERSONAL ASSESSMENT:

Recently I have had job performance difficulties:	None <input type="checkbox"/>	Slightly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Frequently <input type="checkbox"/>
Recently I have had difficulty with normal social activities:	None <input type="checkbox"/>	Slightly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Frequently <input type="checkbox"/>
My current physical health is:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>

 How many days of work have you missed or been tardy in the past month? 

Married/Separated/Divorced (dates): \_\_\_\_\_

Dependent(s) Name(s)/age(s): \_\_\_\_\_

Medical Conditions and Medications: \_\_\_\_\_

Dates, Duration, and providers of all past counseling: \_\_\_\_\_

Signature: \_\_\_\_\_

 I (we) give consent to H & H Health Associates, Inc. to provide counseling services for \_\_\_\_\_  
 (minor child) for whom I am responsible. Guardian's Signature: \_\_\_\_\_



## **Statement of Understanding Employee Assistance Services**

### **I understand the following:**

The decision to receive services from the Employee Assistance Program (EAP) is strictly voluntary even though clients are sometimes referred to the program by family members, supervisors, union officials, medical staff, and/or other health care professionals.

### **Our Services:**

All services provided by the EAP are at no cost to you or your family members. The EAP contract with your employer allows for a specified number of sessions; however, the number of sessions necessary to assist you is a clinical decision which will be made by your EAP counselor. Cancellations of appointments should be made 24 hours in advance. Only in the case of emergency will the session be interrupted.

The services offered by the EAP include problem assessment, short-term counseling, referral as deemed necessary, and follow-up. Formal medical diagnoses or on-going treatment services are not provided. Such services are provided by qualified professional agencies and individuals in the community.

The EAP services provided to you may include referring you to independent medical or mental health resources for on-going assistance. If a referral is made, the EAP will usually provide two or three resource options. The final choice will be your responsibility. These referrals are made in consideration of our assessment of your needs. The EAP receives no reimbursement from any referral source.

If a referral for on-going treatment services is required, your EAP counselor will consider your insurance benefits and ability to pay, and will discuss these matters with you. However, you are responsible for final verification of insurance coverage and any co-payments or charges not covered by your insurance.

### **Confidentiality/Access to Privileged Information:**

All case records and information about clinical services provided to you by the EAP will be maintained in the strictest confidence possible under law.

Specific information contained within your case records will not be released to any party without your written authorization except pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 and Missouri state or Federal law. These include reporting abuse, neglect and domestic violence; addressing serious threats to health or safety; and law enforcement purposes.

**If you wish to contact us for further information or to file a complaint, please contact Tim Hobart, Privacy Officer, telephone 314.845.8302.**

**Your initials submitted on the enclosed “EAP Intake Form” acknowledge consent to this policy.**



## NOTICE OF PRIVACY PRACTICES H&H HEALTH ASSOCIATES, INC.

**Effective April 14, 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"). We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our privacy notice and to make the new notice provisions effective for all protected health information we maintain. In the event we should change our privacy notice, we will provide you with a revised notice at your next visit. We must promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in this notice. Except when required by law, a material change to any term of this notice may not be implemented prior to the effective date of the notice in which such material change is disclosed to you.

Your written authorization and specific provisions of the Privacy Regulations govern disclosure of your protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoke in writing as provided in the Privacy Regulations. The company is permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment and health care operations. For example, protected health information may be disclosed from one staff member to another within the company for consultation.

Subject to requirements of the Privacy Regulations, we may use and disclose protected health information for purposes of complying with legal requirements; public health activities; reporting abuse, neglect and domestic violence; cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations; for judicial and administrative procedures; for law enforcement; with respect to decedents; regarding cadaveric organ, eye and tissue donation; serious threats to health or safety; specialized in government functions; and incident to a use or disclosure otherwise permitted or required by the Privacy Regulations, as provided under the Privacy Regulations. We may also disclose protected health information pursuant to your agreement to persons indicated by you for involvement in your health care for notification purposes.

Missouri state laws with respect to genetic information and to human immunodeficiency virus infection status are more stringent than the Privacy Regulations and protected health information regarding these matters will be disclosed only in accordance with the governing Missouri statutes.

You have certain rights with regard to the handling of your protected health information, as provided in the Privacy Regulations, these are as follows: You may request restrictions on certain uses and disclosures of protected health information however, we are not required to agree to a requested restriction; You may receive confidential communications of protected health information as provided by the Privacy Regulations; You may inspect and copy your protected health information, pursuant to a written request, subject to certain restrictions in the Privacy Regulations, such as restriction on access to psychotherapy notes; You have a right to appeal a denial of access to your records; You may request an amendment of protected health information and demographic information, pursuant to a written request, subject to certain limitations in the Privacy Regulations; You have a right to contest a denial of an amendment; You may receive an accounting of certain disclosures of protected health information; You may obtain a paper copy of this notice upon request and a copy of your written acknowledgement of receipt of this notice.

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. If you wish to contact us for further information or to file a complaint, please contact Tim Hobart, Privacy Officer, telephone 314.845.8302. We will not take any action against you for filing a complaint or for exercising your rights under the Privacy Regulations.

**Your initials submitted on the enclosed "EAP Intake Form" acknowledge consent to this policy.**

# Client Satisfaction Survey

**Thank you** for completing the Customer Satisfaction Survey.

We would like to know your level of satisfaction with H&H Health Associates' EAP services. Please take a few minutes to share your opinions. Your responses are confidential and individual ratings will not be reported.

By mail: H&H Health Associates, Inc.  
 11132 South Towne Square, Ste. 107  
 St. Louis, MO 63123

By fax: 314.845.8087

By email: Please go to: [www.hhhealthassociates.com](http://www.hhhealthassociates.com) and click on the contact tab.

Please rate your satisfaction level with each of the following statements.

- 1 = completely satisfied/agree
- 2 = mostly satisfied/agree
- 3 = dissatisfied/disagree
- 4 = N/A

Services	1	2	3	4
1. Counseling was at a convenient time and location for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Help-line staff were courteous, professional, and knowledgeable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I was served in a confidential manner.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I recommend my employer continue providing the EAP.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I would use the EAP again.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## My counselor was:

6. Helpful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. A good listener.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Understanding of my concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Professional.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Counselor's name:

## Company

10. Overall, how satisfied are you with H&H Health Associates, Inc. as a company?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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11. How can H&H Health Associates, Inc improve your customer experience?

Your feedback helps us continually improve H&H Health Associates' services to you.  
 If you'd like to speak with someone from H&H, you may contact Tim Hobart, CEO at 314.845.8302, ext. 207

**H&H Health Associates, Inc.**  
**EAP CLINICAL DISCHARGE SUMMARY**

Client Name(s):

Closing Date:

**Resolution / Closing Recommendation: (Following section based on counselors assessment):**

 Issue resolved 

 Referred to an outside resource 

 Referred to an internal resource 
**Outcome in the Workplace:**

 Improved: Morale  Productivity  Absenteeism  No Change 

 Global Assessment of Functioning (GAF) Decrease  Increase  No Change 

 Achievement of Counseling Goals: No  Partly  Yes 
**Performance Impairment:** Deteriorated  Improved  No Change 
**Absence:** Deteriorated  Improved  No Change 

 Client Satisfaction Survey Distributed: Yes  No 
**DSMIV-R:**

Axis I: Axis II: Axis III:

Axis IV: Axis V:

**PERSONAL ASSESSMENT (BASED ON CLIENT'S RESPONSES):**

 Recently I have had job performance difficulties: None  Slightly  Moderately  Frequently 

 Recently I have had difficulty with normal social activities: None  Slightly  Moderately  Frequently 

 My current physical health is: Excellent  Good  Fair  Poor 

 How many days of work have you missed or been tardy in the past month? 

Clinician Signature:

Clinician Name (Print):

Clinician Direct Phone:

E-mail Address: