Saint Alphonsus
6140 Emerald. • Boise, ID 83704 • (208) 367-3300
EMPLOYEE ASSISTANCE PROGRAM

Client Name: _____
Client ID: _____
Date: _____

CONSENT TO TREAT A MINOR

Permission is granted for the Saint Alphonsus Employee Assistance Program (EAP) and its Associates and Employees to provide evaluation, counseling, and/or referral assistance to:

_____
(Name of Minor Child)

I verify that I am the responsible parent or legal guardian of this child. I have had sufficient opportunity to discuss the condition, the proposed treatment, the likelihood of success, risks, benefits, and side effects of the proposed treatment, alternative treatments and non-treatment, and the likelihood of success, risks, benefits and side effects of such alternative treatments and non-treatment with my doctor, and all of my questions have been answered to my satisfaction.

I understand that I may revoke this consent at any time by informing, in writing to the EAP. Otherwise, this consent shall expire after a period of 90 days from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any and all liabilities arising there from.

_____ _____
Signature of Parent of Legal Guardian Date

_____ _____
Signature of Minor (if possible) Date

_____ _____
Signature of Witness Date

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CHILD CLIENT INFORMATION FORM

*All identifying information is confidential, to the extent permitted by law.

Today's Date: _____ Been Here Before? ☐ Yes ☐ No When?: _____

Name: _____ Date of Birth: _____ Age: ___ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Cell: _____ Home: _____

Work: _____ Ok to Leave Message?: ☐ Cell ☐ Home ☐ Work

Mother's Email: _____ OK to email?: ☐ Yes ☐ No

Father's Name: _____ Cell: _____ Home: _____

Work: _____ Ok to Leave Message?: ☐ Cell ☐ Home ☐ Work

Father's Email: _____ OK to email?: ☐ Yes ☐ No

Guardian/Other: _____ Cell: _____ Home: _____

Work: _____ Ok to Leave Message?: ☐ Cell ☐ Home ☐ Work

Guardian/Other Email: _____ OK to email?: ☐ Yes ☐ No

Marital Status of Parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

If divorced, who has legal/physical custody?: _____

Emergency Contact: _____ Phone number: _____

Referred by: ☐ Self ☐ Supervisor ☐ HR ☐ Co-worker/Friend ☐ Family

Has your child ever received any kind of counseling services? ☐ Yes ☐ No

When: _____ Therapist: _____

The information below pertains to the employee of the company providing this benefit.

Name of Company Providing this Benefit: _____

Employee Name: _____ Employee's Date of Birth: _____

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Client Name: _____
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SUMMARY LIST

	SUBSTANCE	REACTION
ALLERGIES Adverse Drug Reaction		

CURRENT MEDICATIONS/DATES	

SIGNIFICANT MEDICAL OR PSYCHIATRIC ILLNESS	

Signature

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STATEMENT OF UNDERSTANDING

Welcome to the Employee Assistance Program (EAP). Your employer sponsors this EAP to help employees and family members resolve personal problems.

SERVICES:

Your EAP counselor will help evaluate your situation and develop an action plan for resolving the problem. This action plan may include additional EAP sessions (up to the limits of your company's contract with us), or you may be referred to providers outside of the EAP who have expertise in your area of need.

The EAP ***does not provide*** long-term therapy; neither does it provide specialized evaluations such as psychological testing, custody evaluations, or court-ordered evaluations. However, we will help you identify appropriate resources to meet these needs.

CONFIDENTIALITY:

EAP services are confidential. We will not reveal information about our work with you to any outside person or agency, including your employer, without your written permission. The only exception to confidentiality is by court order, or in those situations that are life threatening, involve suspected abuse or neglect of a child or vulnerable adult, or represent the commission or threat of a crime on the EAP premises.

COSTS AND APPOINTMENTS:

EAP services are customized by the employer and usually are paid in full by the employer. Some plans may require copay after a certain number of visits. Your counselor will be able to explain the details of your plan. If you accept a referral to a provider in the community, you will be responsible for any costs associated with those services. You should check your health care benefits to determine if those costs might be covered by your health insurance.

EAP sessions will usually last 45-60 minutes. Your counselor will make every effort to begin and end the sessions on time. **If you fail to appear for a session, or cancel a session with less than 24 hour notice, we will either count that session against the total allowed by the employer or you may be charged for the time that was allotted to you, depending on your plan.** Your counselor will be able to answer questions about this policy.

THE SAINT ALPHONSUS EAP:

The Saint Alphonsus EAP is a department of Saint Alphonsus. All counselors have earned advanced degrees and maintain state licenses. If you have additional questions about the EAP, ask your EAP counselor or the Office Manager.

FEEDBACK QUESTIONNAIRE:

In order to monitor the effectiveness of the EAP and identify ways of improving our services, after we complete our work together we would like to send you an anonymous feedback questionnaire. Please select from the following options.

☐ Please email the questionnaire to the following address:_____

☐ Please mail the questionnaire to the following address: _____

☐ No, please do not mail me a feedback questionnaire.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I have been offered the Saint Alphonsus Notice of Privacy Practices that provides information about how the facility may use and disclose Protected Health Information (PHI) for purposes of treatment, payment and health care operations. _____ ***Please initial***

I have read this statement and accept, understand, and acknowledge its conditions and contents.

_____ _____

Signature of Client or Legal Guardian Date

_____

Name of Client (Please Print)