Interface EAP *www.ieap.com*

Employee Assistance Programs – Mental Health Care Management

EXPLANATION OF EAP AND RELEASE OF INFORMATION

PROVIDER MUST SUBMIT A COPY OF THIS SIGNED FORM TO RECEIVE PAYMENT FOR **EAP** SESSIONS.
PATIENT MUST RECEIVE A COPY OF THIS FORM

Patient Name: _____ **IEAP Case #:** _____
Please print –REQUIRED *REQUIRED*

Provider Name: _____
Please print -REQUIRED

DESCRIPTION OF SERVICE: Your employer has contracted with Interface EAP to provide you and your eligible dependents an Employee Assistance Program (EAP) to handle assessment and treatment of short-term problems. This benefit is free to you and sessions are limited in number according to your employer's contract.

Interface EAP has authorized **one** of your available EAP sessions to this provider in order to assess the problem and make recommendations on the type and length of treatment needed to resolve your individual problem.

It is your responsibility to contact Interface EAP before any additional sessions will be authorized. After your first visit with the provider, you will need to call an Interface care coordinator at 713-781-3364 or 1-800-324-4327 to discuss treatment recommendations. It is best to call Interface EAP (2) two working days AFTER you have had your first session with this therapist. Additional unauthorized sessions will be your financial responsibility**.**

TREATMENT RECOMMENDATIONS: Your provider will recommend a course of treatment, which may include: use of your remaining EAP sessions, a referral to a community resource, or, in some cases, a referral for long-term treatment under your health insurance benefits. If your health insurance option is chosen, it is your responsibility to check eligibility, deductible, and co pay through your insurance plan.

CONFIDENTIALITY: Use of the EAP benefit is confidential. Interface EAP cannot release any information about you without your prior written consent or as required by law. Your provider will be able to answer any questions or concerns you may have.

GRIEVANCE PROCEDURE: If you are dissatisfied with the service you receive, you may register your complaint by telephone or mail. Write to Interface EAP at P.O. Box 421879, Houston, TX 77242-1879, or call (713) 781-3364 or 1-800-324-4327.

I have reviewed and understand the information above. By signing this form, I agree to allow the results of this assessment, including clinical and referral information, to be disclosed to an Interface EAP care coordinator for the purpose of authorizing additional care and process EAP billing.

_____

Patient's Signature (If under 18, signature of parent, guardian or authorized representative) REQUIRED *Date*

_____

Witness or Provider Signature REQUIRED *Date*

You may withdraw your consent at any time. Any withdrawal of consent will not affect the legality of any release of information, which has already taken place due to this signed document. If not revoked sooner in writing, this consent will expire one year from the date signed. A copy of this release is valid.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of the information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2).