County of Ventura

Employee Assistance Program (EAP)

Date: ____________________

Phone #: (check if EAP can leave message)

Name: ____ ☐ Home: ______________

Employee name (If different): ______________________________ ☐ Work: ______________

Address: ____ ☐ Cell: ______________

City: ______________________________________ Zip: ____________________

Dob: ______________ Age : __________ Gender : M/F Number of children: ____ Ages: ____________

Marital status: **(circle one)** Single / Married / Domestic Partner / Divorced / Widowed

Insurance medical plans: ____

Please list any medications you are currently taking: ____________________________________

______________________________________ Prescribed by: ________________________

Emergency contact: ________________________ Relationship: ____________ Phone: ____________

VENTURA COUNTY EMPLOYEES ONLY

Employee ID#: ______________________________ Length of Employment: ____________________

Department: ____ Job Title: ____________________

History Checklist: **(please check all that apply)**

☐ Recent loss or major life changes

☐ Eldercare issues

☐ History of trauma (event or life circumstance)

☐ Workplace concerns

☐ Learning/Educational issues

☐ Legal issues/Worker' Compensation/Disability

☐ Injuries/operations/hospitalizations: ____________________

____

☐ Currently receiving counseling services

☐ Received counseling services in the past? If yes list:

____

Current Symptom Checklist: **(please check all that apply within the past month)**

☐ Feeling sad or blue

☐ Feeling everything is an effort

☐ Trouble with sleep (too much or too little)

☐ Feeling hopeless about the future

☐ Issues with concentration

☐ Difficulty at work or school

☐ Anger issues

☐ Appetite (too much or too little)

☐ Nervousness/shakiness/anxiety

☐ Loss of interest or lack of energy

☐ Heart pounding/racing

☐ Marital/relationship issues

☐ Difficulty at home/family relationships/parenting

☐ Difficulty socializing or being with others

☐ Concern about drug, alcohol or prescription use

Other health issues: ____

Any other events you believe would be important to discuss today: ____________________________

____

County of Ventura
EMPLOYEE ASSISTANCE PROGRAM (EAP)
GENERAL CONSENT FOR EVALUATION

CLIENT:____ DATE OF BIRTH:__________AGE: ____

I, the undersigned, hereby authorize and give my consent to the Employee Assistance Program's (EAP) Representative to conduct a clinical assessment. The purpose of this assessment is to assist in defining the nature of the problem, examine possible solutions, as well as facilitate a referral to the appropriate resource when necessary.

I am aware that, as an employee or a dependent of an employee, I am eligible for 1-5 assessment sessions. The number of assessment visits may vary at the discretion of the EAP Representative, depending on the nature of the problem.

I understand that the EAP does not guarantee any employee immunity or protection from disciplinary action for past and/or present job-related performance problems.

I understand that the EAP protects my health information in a manner prescribed by law, as outlined in the Notice of Privacy Practices to be provided me prior to my consent for evaluation. I understand that if I have any questions regarding the Notice of Privacy Rights, I can contact the Privacy Officer through the County of Ventura Human Resources Division, 800 S. Victoria Ave., Ventura, CA 93009 (805-654-3197).

In compliance with the standards set forth in the Notice of Privacy Practices, I understand that disclosure of my health information may occur or be specifically required of a licensed professional by law in the following instances:

a) To report and/or prevent child or elder abuse
b) To prevent imminent harm to client or others
c) Pursuant to subpoena or other court order
d) In the course of an investigation by a Coroner or Medical Examiner

I understand that the EAP may inform my Primary Care Physician of any specific referral in an effort to properly coordinate care.

I understand that the EAP may have contact with my designated health care plan for the purpose of determining benefit eligibility, level of coverage, and coordination of benefits.

_____CANCELLATION POLICY: The EAP is a resource and benefit for all County employees. Cancellations or missed appointments can impact our availability to others. Please consider this when making appointments with staff. Two missed appointments or cancellations may result in our decision to offer other alternatives.

I hereby agree with the terms for evaluation as well as acknowledge receipt of the EAP's Notice of Privacy Practices. I understand I have the right to receive a copy of this authorization.

CLIENT SIGNATURE DATE

LEGAL GUARDIAN SIGNATURE DATE

(If 11 years old or under, the legal guardian signs)
(If 12 to 18, the legal guardian/parent and the minor sign)

COUNTY OF VENTURA

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Behavioral Care and Primary Care Physician (PCP)

Coordination of Care Form

Communication between behavioral health providers and family physicians is important to ensure comprehensive, quality health care. Should it be your preference, this form will allow the EAP Representative to share necessary behavioral health information with your primary care physician and/or other healthcare provider/s. Information cannot be released without this signed authorization.

Client Name:____ Date:__________________________

Name of Primary Care Physician (PCP) or other Healthcare Practitioner: ______________________________

____Phone:_____________________

Name of Behavioral Health Practitioner:_____________________________Phone:_____________________

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

_______I give my permission for release of the following information:

I authorize the release/exchange of necessary medical, psychological, and/or educational information between the EAP and my primary care physician or other designated healthcare practitioner. The purpose of disclosure is to better assure the continuity and/or coordination of my behavioral health and/or medical care.

All information received is considered confidential and will be kept by the EAP in accordance with all State and federal mandates. This authorization will remain valid for one year from the date signed and is revocable at any time. I also understand that I am entitled to a copy of this form.

________I do NOT wish to have information shared.

I refuse to authorize the release/exchange of information between the EAP and any other provider of care at this time.

____ ____________________________

SIGNATURE OF Patient or Legal Guardian **Date**

DATE FORM WAS: MAILED ____________ OR FAXED ___________ TO PCP

AUTHORIZATION TO COMMUNICATE VIA EMAIL

In an effort to communicate in a more timely and efficient manner, the EAP would like to utilize your email to contact you regarding general follow-up communication, missed or pending appointment confirmations, and/or to invite you to participate in a Client Satisfaction Survey. In accordance with the Notice of Privacy Practices, please read and sign the authorization below.

The following is my authorized e-mail address:

____

(Please Print Email Clearly)

If this is a County email please note that the privacy and security of email communication cannot be guaranteed.

Please check if **<u>you are not</u>** interested in email correspondence __________

____ ________________________

Client Name (please print) Date

____ ________________________

Patient or Guardian's Signature Date

County of Ventura
Employee Assistance Program

TELETHERAPY CONSENT FORM

(REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY)

Definition of Services:

I,________________________________, hereby consent to engage in teletherapy with __________________________. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of California. (This is a legal requirement for therapists practicing in this state under a CA license.)

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

County of Ventura

Employee Assistance Program

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with

____.

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the Crisis Team at 1.866.998.2243 or the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read, understand and agree to the information provided above regarding telehealth:

Client's Signature:_________________________________Date:_______________

Therapist's Signature:______________________________Date:_______________