TriCounty
Employee Assistance Program
Enhancing Productivity Since 1980

INTAKE INFORMATION FORM

EMPLOYEE INFORMATION

Name of Employer: _____

Who referred you? ☐ Employer ☐ Relative ☐ Probation ☐ Friend ☐ Self ☐ Physician ☐ Other Clinician ☐ Union ☐ other (please explain) _____

SSN: _____ Date of Birth_____ Age_____

Name of Employee _____ Occupation_____

Home Address _____City _____Zip Code _____

Home Phone _____ Work Phone _____Cell Phone _____

E-Mail Address _____May we contact you by: phone: ☐ Y ☐ N By E-mail ☐ Y ☐ N

Education _____ Marital Status _____ Race _____Gender ☐ Male ☐ Female

CLIENT INFORMATION

Student Status _____ Place of Employment_____

Referred by: ☐ Employer ☐ Relative ☐ Probation ☐ Friend ☐ Self ☐ Physician ☐ Other Clinician ☐ Union ☐ other (please explain) _____

Client Name _____ Date of Birth _____ Age _____

Home Address _____City _____ County _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail Address _____May we contact you by: phone: ☐ Y ☐ N E-mail ☐ Y ☐ N

Occupation_____ Education _____ Marital Status _____

Race _____ Gender ☐ Male ☐ Female SSN: _____

PHYSICIAN'S INFORMATION

Name _____ Telephone Number _____

Address _____ City _____ Zip Code _____

IN CASE OF EMERGENCY Contact Name _____
Telephone Number _____ Relationship to you _____

INSURANCE INFORMATION Name of Carrier _____ Name of insured person if different than employee_____ Policy Number _____Group Number _____

WHAT BRINGS YOU HERE AT THIS PARTICULAR TIME? ***(a short statement of your concern)***

_____
_____
_____
_____

Continued on back

MILITARY HISTORY ☐Y ☐N

FAMILY HEALTH

Relative	Present Age	Significant Health Problems	Age of Deceased
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse	_____	_____	_____
Siblings'	_____	_____	_____
Children	_____	_____	_____

MEDICAL INFORMATION

Have you ever been hospitalized? ☐ **Yes** ☐ **No**

List any operations _____ **Name of Hospital** _____ **Date** _____

List the Illness_____ **Name of Hospital** _____ **Date**_____

List the Illness_____ **Name of Hospital** _____ **Date**_____

List the Illness_____ **Name of Hospital** _____ **Date**_____

PLEASE CHECK ALL THAT APPLY

☐ Rheumatic Fever
☐ Frequent Headaches
☐ Medical Eye Trouble
☐ Heart Disease
☐ Tuberculosis
☐ Jaundice
☐ Medicine Reaction
☐ Painful Urination
☐ Depression
☐ Nervous Problem
☐ Anxiety Attacks
☐ Asthma
☐ Tumor, Cancer
☐ Growth, Cyst
☐ Ear, Nose Problems
☐ Chest Pain/Pressure
☐ Shortness of Breath
☐ Pancreatitis
☐ Arthritis
☐ Rheumatism
☐ Venereal Disease
☐ Hepatitis
☐ Kidney Disease
☐ Hepatitis
☐ Other, please list_____

Date of Last Physical _____ **Physicians Telephone Number** _____

Name of physician if different than previously listed_____

Please list any counselors, psychologists, or psychiatrists the client is seeing or has seen in the past.

Name	Title	Date
_____		
_____		
_____		

Medications - please list current medications

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

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CLIENT INFORMATION SHEET
CLIENT'S RIGHTS AND CLIENT GRIEVANCE POLICY AND PROCEDURES

APPOINTMENTS

The average individual counseling session is fifty (50) minutes. If it is necessary to cancel a session, please do so 24 hours or more in advance. If you have two (2) no shows and/or cancellations without a 24-hour notice you will lose your choice of preference for a specific counselor and counseling time.

GETTING IN TOUCH

You may call your therapist between sessions if you have a need. If your therapist is not available when you telephone, and another counselor is available, she or he will take your call and offer help with your concern. In case of emergency, Tri-County EAP has a 24-hour answering service.

BAD WEATHER

Tri-County EAP will close when driving is especially hazardous. If you have any questions as to whether we are open, please call. Our staff or our answering service operators will be able to advise you.

RESPONSIBILITY FOR PAYMENT

1. _____ counseling sessions will be provided to you per contract year, without charge, as provided by the pre-paid plan your employer has with Tri-County EAP

2. Subsequent visits: Insurance is billed after your no charge visits have been used. Copayments are due at time of service. The Client is responsible all amounts not covered by your insurance company. If you have an HMO and/or Tri-County is not on panel, you will be directed to one of their providers for additional counseling. Our billing charge is $90.00

3. Tri-County EAP will send all bills directly to your home address.

4. It is noted that no person is a "dependent" if he/she is eligible for this plan as an employee of any organization for which Tri-County Employee Assistance Program provides employee assistance services. Dependent eligibility is subject to specific conditions.

I have read, understand and agree to the above conditions. I have received a copy of Client Rights. Client Grievance Procedure and Policy will be provided upon request and is posted in the waiting room.

_____ _____ _____ _____

Signature of Client or Client's Guardian | Date | Signature of Witness | Date

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PERMISSION FOR TREATMENT

I hereby request care and treatment for _____
(Name of person receiving treatment)

at Tri-County Employee Assistance Program (EAP). I understand that the staff of Tri-County EAP may utilize any of the procedures and treatments customarily used in an out-patient counseling facility. It has been explained to me that customary care may include assessment, psychological testing, psychotherapy, counseling, and referral. I understand that I may discuss the possible effects of treatment with the counselor and that I may change counselors at any time. I also understand that Tri-County has a written grievance procedure that I may activate at any time.

For those who are seeking counseling for a child or adolescent under 18, whose parents are separated or divorced: please write the names of all persons whom the court has designated as having parental rights to seek medical/psychological treatment.

_____
_____
_____
_____

I understand that the counselor is, or works under the supervision of, a psychologist, who is licensed by the Ohio Board of Psychology. I can request a meeting with the counselor's supervisor at any time to discuss any concerns I may have.

Signature of client :_____ **Date:**_____
(*or if client is under 18, signature of parent/guardian*):

Signature of witness:_____ **Date:**_____

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Insurance Consent

I,_____ _____
Client Name Date of Birth or Social Security Number

_____ _____
Name of insured person, if different than above. Date of Birth or Social Security Number

hereby grant my permission to Tri-County Employee Assistance Program to:

_____ Release to _____ Receive from __x__ Exchange with my health insurance carrier.

Name of the insurance carrier:_____
The following specific information: regarding psychological treatment and diagnosis, including alcohol and drug use.

The purpose of this disclosure is:

__X__ Insurance or other third party reimbursement

_____ Continuity of care and treatment planning

_____ Other (specify) _____

I may revoke this consent at any time except when disclosure has already been made. I hereby state that I have read or have had read to me and fully understand the above statements as they apply to me and do expressly consent to disclosure of the above-stated information.

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42C.F.R., part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____
Signature of Client or authorized representative

_____
Relationship to client

_____
Date of signature

_____
Signature of witness and date

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CONFIDENTIALITY OF CLIENT RECORDS

The confidentiality of client records maintained by Tri-County Employee Assistance Program is protected by Federal law and regulations. Generally, the program may not disclose to a person outside the program that an individual is a client of Tri-County Employee Assistance Program or disclose any information concerning that individual, unless:

1. The individual consents in writing;
2. The disclosure is allowed by a court order;
3. The disclosure is made to medical personnel in a medical emergency or;
4. The disclosure is made to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a counseling program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client, either at the counseling program or against any person who works for the program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Your counselor or counselor intern is required by law to report information about alleged child abuse/neglect, elder abuse, and abuse of a mentally retarded or developmentally disabled person. She/he is also required to make a case file note if she/he has reason to believe that you have been the victim of domestic violence/abuse.

See 42 U.S.C. 290 DD-3 and 42 U.S.C. 290 EE-3 for Federal laws and 42 CFR part two, Federal regulations.

I have been informed of the above information concerning the confidentiality of client records, and acknowledge that I have received a copy of Tri-County Employee Assistance Program's Client's Rights and Brochure.

_____ _____

Signature of Client Date Signature of Witness Date

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

If you have any questions about this Notice, please contact Ruth Llewellyn at (330)762-7908

OUR DUTIES

At TriCounty EAP we understand that health information about you and your health is personal. We are committed to protecting health information about you and safeguarding that information against unauthorized use or disclosure. We are required by law to: 1) maintain the privacy of your health information; 2) provide you notice of our legal duties and privacy practices with respect to your health information;3) to abide by the terms of the notice that is currently in effect; and 4) to notify you if there is a breach of your unsecured health information.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH IFORMATION

When you receive services paid for in full or part by the Board, we receive health information about you. We may receive, use or share that health information for such activities as payment for services provided to you, conducting our internal health care operations, communicating with your healthcare providers about your treatment and for other purposes permitted or required by law. The following are examples of the types of uses and disclosures of your personal information that we are permitted to make:

Payment- We may use or disclose information about the services provided to you and payment for those services for payment activities such as confirming your eligibility, obtaining payment for services, managing your claims, utilization review activities and processing of health care data.

Health Care Operations- We may use your health information to train staff, manage costs, conduct quality review activities, perform required business duties, and improve our services and business operations.

Treatment- We do not provide treatment but we may share your personal health information with your health care providers to assist in coordinating your care.

Other Uses and Disclosures- We may also use or disclose your personal health information for the following reasons as permitted or required by applicable law: To alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; to reduce or prevent threats to public health and safety; for health oversight activities such as evaluations, investigations, audits, and inspections; to governmental agencies that monitor your services; for lawsuits and similar proceedings; for public health purposes such as to prevent the spread of a communicable disease; for certain approved research purposes; for law enforcement reasons if required by law or in regards to a crime or suspect; to correctional institutions in regards to inmates; to coroners, medical examiners and funeral directors (for decedents); as required by law; for organ and tissue donation; for specialized government functions such as military and veterans activities, national security and intelligence purposes, and protection of the President; for Workers' Compensation purposes; for the management and coordination of public benefits programs; to respond to requests from the U.S. Department of Health and Human Services; and for us to receive assistance from consultants that have signed an agreement requiring them to maintain the confidentiality of your personal information. Also, if you have a guardian or a power of attorney, we are permitted to provide information to your guardian or attorney in fact.

Uses and Disclosures That Require Your Permission

We are prohibited from selling your personal information, such as to a company that wants your information in order to contact you about their services, without your written permission.

We are prohibited from using or disclosing your personal information for marketing purposes, such as to promote our services, without your written permission.

All other uses and disclosures of your health information not described in this notice will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the purposes stated in your written permission except for those that we have already made prior to your revoking that permission.

Prohibited Uses and Disclosures
If we use or disclose your health information for underwriting purposes, we are prohibited from using and disclosing the genetic information in your health information for such purposes.

POTENTIAL IMPACT OF OTHER APPLICABLE LAWS

If any state or federal privacy laws require us to provide you with more privacy protections than those explained here, then we must also follow that law. For example, drug and alcohol treatment records generally receive greater protections under federal law.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights regarding your health information:

- Right to Request Restrictions. You have the right to request that we restrict the information we use or disclose about you for purposes of treatment, payment, health care operations and informing individuals involved in your care about your care or payment for that care. We will consider all requests for restrictions carefully but are not required to agree to any requested restrictions.*
- Right to Request Confidential Communications. You have the right to request that when we need to communicate with you, we do so in a certain way or at a certain location. For example, you can request that we only contact you by mail or at a certain phone number.
- Right to Inspect and Copy. You have the right to request access to certain health information we have about you. Fees may apply to copied information.*
- Right to Amend. You have the right to request corrections or additions to certain health information we have about you . You must provide us with your reasons for requesting the change.*
- Right to An Accounting of Disclosures. You have the right to request an accounting of the disclosures we make of your health information, except for those made with your permission and those related to treatment, payment, our health care operations, and certain other purposes. Your request must include a timeframe for the accounting, which must be within the six years prior to your request. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Right to a Paper Copy of Notice. You have the right to receive a paper copy of this Notice. You may obtain a paper copy by contacting the Privacy Officer.

To exercise any of the rights described in this paragraph, please contact the Privacy Officer at:
TriCounty EAP, 580 Grant Street, Akron, Ohio 44311
(330)762-7908 or email lruth@tceap.org

* To exercise rights marked with a star (*), your request must be made in writing.
Please contact us if you need assistance.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of our current Notice at our office. In addition, each time there is a change to our Notice, you will receive information about the revised Notice and how you can obtain a copy of it. The effective date of each Notice is listed on the first page in the top center.

TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the **TriCounty EAP** (see above) or with the Secretary of the Department of Health and Human Services. **To file a complaint with TriCounty EAP**, **contact the Privacy Officer at the address above**. You will not be retaliated against for filing a complaint. If you wish to file a complaint with the Secretary you may send the complaint to: Office for Civil Rights, U.S. Department of Health and Human Services, Attn: Regional Manager, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.

_____

Client Signature Date

_____

Witness Date

HAMILTON SURVEY FOR EMOTIONAL AND PHYSICAL WELLNESS

Dr. Gregory Knopf MD

NAME:_____ DATE:_____

Instructions: Think over the past two weeks and rate yourself for each question as you identify with the phrases, symptoms and feelings.

On a scale of (0-4). 0 =NONE, 1=MILD, 2=MODERATE, 3=SEVERE, 4=EXTREME.

_____1) **Depressed Mood**:
I find myself feeling very sad and helpless, either because of the present circumstances or for no reason at all. I feel a sense of hopelessness that things will never get better. I find myself crying more frequently and am not able to "hold it together." I often feel worthless.

_____2) **Guilt Feelings:**
I sometimes feel like I should be punished. I really do not like myself right now and maybe I deserve some of the things that are happening to me. Even though I can't think of specific examples, I feel guilty much of the time.

_____3) **Suicide:**
I often find myself thinking about death and sometimes wish that I didn't have to live anymore. My life seems empty and not worth the effort it is taking. I find myself wanting to avoid other people and be alone. I've told at least one other person that it would be better if I were dead or gone. Sometimes I find myself wanting to cut myself or think about taking a lot of pills.

_____4) **Initial Insomnia:**
I have difficulty falling asleep after I get into bed at night.

_____5) **Middle Insomnia:**
I have difficulty sleeping all night long without interruption. I wake up for no reason several times during the night. I sometimes get back to sleep and sometimes not.

_____6) **Delayed Insomnia:**
I find myself waking up 2-3 hours before I want to, for no reason, and cannot get back to sleep.

_____7) **Work and interest:**
My job and family are no longer enjoyable. I often find myself not caring about my job or home responsibilities. I rarely do any of the hobbies that I used to enjoy. My friends invite me to do things, but I often find reasons to say no. The things that I use to enjoy don't seem to lift my spirits. People at work are noticing that the quality of my work has deteriorated. My family members are beginning to complain that I don't do the usual things around the house that I did in the past.

_____8) **Alertness:**
I find myself feeling sluggish in my ability to think, communicate my ideas, and sometimes just moving around.

_____9) **Agitation:**
I find myself fidgeting and feeling very restless. Often I will pace back and forth or sometimes clench my fists. Sometimes I will tap my feet or hands for no reasons or bite my lips. I often find myself wringing my hands. Sometimes I will pull at my hair or pick at my fingernails or clothes.

_____10) **Anxiety (Psychological):**
I often feel tense and unable to relax. I find myself irritable with family or coworkers. I am easily startled. Even though I try not to, I often worry over trivial matters. Often, I am fearful for no reason. I have a sense that things are going to get worse and I will be unable to do anything to change it. I feel out of control and that I could have a panic attack.

_____11) **Anxiety (Physical):**
I often times have "butterflies" in my stomach. Many times my stomach will cramp or I will have indigestion. Recently I have noted more belching or diarrhea. My heart has begun to beat much faster that it used to. I often find myself feeling like I can't get enough air. Sometimes I have noted tingling in my

fingers or around my mouth. I am sweating more than I used to or feel flushed. I have noticed that my hands have begun to shake slightly. I have recently started having headaches for no reason. I find that I have to go to the bathroom and urinate more frequently, and often smaller amounts.

_____12) **Loss of Appetite:**
Food no longer seems appealing to me. I just don't feel like eating as much as I used to. My friends have expressed concern about my eating habits.

_____13) **Fatigue:**
I feel exhausted almost all the time. I no longer have the kind of energy to function like I used to. I often feel like my arms or legs are heavy. I have wondered if I have "chronic fatigue syndrome."

_____14) **Sexual:**
I have lost my desire for sexual intimacy that I used to have. I am finding that it is not worth the effort to be involved in sex.

_____15) **Fear:**
I am afraid that I might have cancer or something really bad affecting my health. I think a lot about many kinds of symptoms which I have never had before, and it upsets me.

_____16) **Weight Loss:**
I am now losing weight, even though I am not trying to lose weight.

_____17) **Unexplained Pains:**
I have pain in my muscles and around my joints and along my spine. Doctors have not given me a clear reason for the pains because they consider the symptoms too vague. I wonder if I could have "fibromyalgia", I often have headaches and low back pains.

_____18) **Mood Swings:**
I find that my moods can range from high to low, often for no reason, and even on the same day. It upsets me to think that I cannot control my emotions when I am down.

_____19) **Oversleeping:**
I am finding that it is harder to get up in the morning, even though I go to bed on time. I don't get the kind of sleep I would like, and stay in bed for hours at a time.

_____20) **Oversleeping:**
I am sleeping more than ever before. It seems that all I want to do is sleep.

_____21) **Napping:**
It is difficult for me to get through the day without taking a nap or wanting to take a nap. I am so tired by the afternoon that when I come home I can hardly function.

_____22) **Increased Appetite:**
I am finding myself eating more even if I am not hungry. I am having more cravings than ever for certain foods like chocolate. I am eating more during my regular meals and having snacks between meals. My friends have expressed concern about my eating habits. I sometimes binge on junk food.

_____23) **Weight Gain:**
I have gained weight recently. It seems like I am gaining weight even though I am not eating enough to explain the increase.

_____24) **Sluggishness:**
I oftentimes feel almost paralyzed in my ability to process my thoughts and feelings. I am unable to find the will power to do the things I need to do. I just can't think as quickly as I used to.

_____25) **Physical Movement:**
I feel sluggish physically. People ask me if there is something wrong because they say I look sad.

_____ Total