HDC
Human Development Company

CLIENT INTAKE

DATE: _____/_____/_____ **(PLEASE PRINT LEGIBLY)**

CLIENT FIRST NAME: _____ **(MI)** _____ **(LAST)** _____ **DOB:** ____/_____/_____

HOME MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

CELL PHONE: (_____) _____-_____ **OK to call? Y / N**

HOME PHONE: (_____)_____-_____ **OK to call? Y / N**

WORK PHONE: (_____)_____-_____ **OK to call? Y / N**

EMAIL ADDRESS: _____ **HAVE YOU UTILIZED OUR SERVICES BEFORE? Y / N**

EMPLOYEE FIRST NAME: _____ **(MI)** _____ **(LAST)** _____ **DOB:** _____/_____/_____

COMPANY NAME: _____ **JOB CATEGORY/TITLE:** _____

LENGTH of EMPLOYMENT: _____ **years/** _____**months**

THE FOLLOWING INFORMATION IS TO BE COMPLETED FOR/BY THE CLIENT:

GENDER

- ☐ Female
- ☐ Male

MARITAL STATUS

- ☐ Single
- ☐ Married

CASE OPEN ON

- ☐ Employee only
- ☐ Dependent

REFERRED TO EAP BY

- ☐ Self/Family/Peer
- ☐ Supervisor suggested
- ☐ ***Supervisor Formal****

Supervisor's Name:
_____

Supervisor's Number:
(___)_____

WORK PERFORMANCE PROBLEMS

- ☐ Absent
- ☐ Tardy
- ☐ Problems relating to others
- ☐ Workers comp case
- ☐ Alcohol/Drug or positive drug screen
- ☐ Family member
- ☐ No problems on the job

PERSONNEL ACTIONS TAKEN

- ☐ Verbal Warning
- ☐ Written Warning
- ☐ Suspension
- ☐ Termination
- ☐ N/A

JOB CATEGORY

- ☐ Employee/Staff
- ☐ Family member
- ☐ Faculty
- ☐ Retiree
- ☐ Resident physician

PROBLEM(s) PRESENTED BY CLIENT

- ☐ Alcohol/Drug
- ☐ Alcohol/Drug-related (family)
- ☐ Addictions - Other
- ☐ Anxiety
- ☐ Bereavement/Grief
- ☐ Depression
- ☐ Eating disorder
- ☐ Family
- ☐ Financial
- ☐ Legal
- ☐ Marital/Relationship
- ☐ Stress
- ☐ Trauma
- ☐ Work-related

HOW DID YOU HEAR ABOUT US?

- ☐ Posters
- ☐ Brochures
- ☐ Supervisor suggested
- ☐ Co-worker suggested
- ☐ Family suggested
- ☐ Training/Orientation
- ☐ Prior participation

STATEMENT OF UNDERSTANDING

Please check the items below to acknowledge your consent:

- ❑ I am being seen for short-term counseling/coaching through my EAP. My EAP counselor/consultant will advise me if additional or long-term services are warranted and will refer me to an appropriate resource. I am financially responsible for any treatment program to which I may be referred.

- ❑ I understand that I have a right to privacy and to review, request, and/or provide an addendum to information in my records.

- ❑ I am not permitted to bring weapons of any kind on the premises.

- ❑ The only exceptions to confidentiality are in life threatening situations or those involving abuse or neglect, or upon my written consent.

Court-related issues:

- ❑ I will not attempt to use my EAP participation for any related process, court proceeding or court-ordered treatment for anger management, substance abuse, custody issues or any other court-ordered treatment.

- ❑ The EAP cannot be used for litigation or advocate on my behalf and will not write letters on my behalf or voluntarily release information to other counselors, courts, attorneys, schools or agencies to support claims regarding custody, leave time, suspension, disability, workers' compensation, or any other issue.

Excuses from work/school:

- ❑ EAP counselors do not have the authority to **excuse** clients from work/school. However, verification of appointments is available at the front desk.

_____	_____	_____
Signature	Print Name	Date

HDC EMPLOYEE ASSISTANCE PROVIDER

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your protected health information and to provide you with notice describing:

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

- We are not required by law to have your written authorization before we use or disclose to others your protected health information for purposes of providing or arranging for your health care.

- We may be required or permitted by certain laws to use and disclose your protected health information for other purposes without your consent or authorization.

- As our client, you have the rights relating to inspecting and copying your protected health information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your protected health information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and filing a complaint if you think your rights have been violated.

- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE and our privacy practices and procedures from time to time. The Effective Date at the bottom left hand side of this page indicates the date of the most current NOTICE in effect.

- You have the right to receive a copy of our most current NOTICE in effect.

- If you have any questions, concerns or complaints about the NOTICE or your protected health information, please contact Daniel Lee, the Privacy Officer, at 502-589-4357 or toll free at 1-800-877-8332.

_____ _____

CLIENT SIGNATURE **DATE SIGNED**

My signature verifies that I have read and understand the above HIPAA Compliance information.

Effective date: August 17, 2018