OptimaHealth

Client Information

The information you provide is confidential and used for EAP purposes only.

Is this your first visit to Optima EAP? ☐ Yes ☐ No Date _____

Name_____ **SSN** _____

Date Of Birth _____ Age _____ Gender: ☐ Male ☐ Female

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Address _____

City _____ State _____ Zip _____

NOTE: IF WE NEED TO CONTACT YOU, WE WANT TO ENSURE WE MAINTAIN YOUR CONFIDENTIALITY. PLEASE PROVIDE THE BEST NUMBER TO REACH YOU AND INDICATE WHETHER WE HAVE PERMISSION TO LEAVE A VOICEMAIL MESSAGE.

Phone Number *as preferred method of contact _____

This phone number is: ☐ Home ☐ Work ☐ Cell phone ☐ Pager ☐ Other _____

Does EAP have permission to send text appointment reminders and leave a voicemail message at this number? ☐ Yes ☐ No

COMPANY INFORMATION

☐ I am the **EMPLOYEE** of the company providing the EAP benefit. I work for:

Company Name of Employee _____

Business Unit or Department _____ Position _____

☐ I am the **DEPENDENT** of the employee with the EAP benefit.

*__REQUIRED –__ Dependents please provide the following information on the employee with the benefit:

Employee's Name _____ Employee's SSN _____

Employee's Company Name _____

Business Unit or Department _____ Employee's Position _____

LAST _____ FIRST _____ CASE # _____ DATE CLOSED _____ MINOR ___

Optima EAP

Distance Counseling Consent Form

I hereby consent to engage in Distance Counseling with a member of the Optima EAP Clinical Team. I understand that Distance Counseling includes assessment, treatment and education using interactive audio, video and data communication.

I understand and agree to the following:

1. Distance Counseling may not be appropriate for everyone and all situations. I understand that if the Optima EAP Clinical Team member believes that I would be better served by another form of therapeutic services that I will be referred to a licensed mental health provider in my area.
2. The number of Distance Session counseling sessions is equivalent to the number of sessions I would receive if I were having face-to-face sessions. If a recommendation is made for me to transfer to face-to-face sessions, the number of sessions authorized will be determined by a review of the case records. If a session is cut short by technical issues a determination as to whether the session will count against the allotted number of sessions based upon the duration of the session.
3. Distance Counseling occurs within the Commonwealth of Virginia and is governed by the regulations of the Commonwealth Board of Counseling or the Commonwealth Board of Social Work. In a manner of speaking, through Distance Counseling, you are visiting the Clinical Team member in his/her office. The Virginia regulations require that the client be physically located within Virginia at the time of the counseling session.
4. Optima EAP conducts its Distance Counseling sessions using the VSee platform. This platform is fully HIPPA compliant. I understand that there are risks and consequences from Distance Counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of Optima EAP that the my counseling session may be disrupted by technical failure of the VSee platform or the transmission of my information could be intercepted by unauthorized persons.
5. Optima EAP may have need to communicate with me via email. Optima EAP sends all emails related to Distance Counseling using encryption technology. I am to use the same technology if and when I have the need to use email to communicate with Optima EAP.
6. I am responsible for:
    a. Providing the necessary telecommunications equipment and internet access for my Distance Counseling sessions;
    b. The information security of the telecommunications equipment being used, and
    c. Arranging for a location for my counseling session that is private and free from distractions;
    d. Disclosing to the Clinical Team member the location where I am at the time of the counseling session.
7. Optima EAP's Distance Counseling does not provide emergency services. During our first session, the Optima EAP Clinical Team member will work with me to create an emergency response plan. If I am experiencing a life-threatening emergency I understand I can call 911 or proceed to the nearest hospital emergency room for help. In the case of an urgent, but non-life threatening event, I can call the Optima EAP 24 hour a day crisis line at 800-899-8174.

_____
Date

_____
Signature of Client (Typed Name Represents an Electronic Signature)

_____
Signature of parent or guardian if client is a minor

Optima EAP Statement of Understanding

You have chosen to receive Employee Assistance Services through Optima EAP. These services may include an assessment, brief-solution based counseling and possible referral for long-term counseling.

EAP Services are offered at no cost to employees and dependents. Your employer has already paid for these services. However, if you need long-term counseling or a specialized service, the EAP will assist you in locating a resource or service in the community. ***It is your responsibility to pay for services provided by outside resources.*** (Your benefit plan may cover some or all of the cost of the service. You may wish to check with your benefits representative before services are provided by a community resource.)

Your sessions with an EAP Counselor are confidential. The EAP will maintain confidential records of your contact with the EAP and the services you receive in order to provide continuity and coordination of your care. No information concerning your participation in the EAP will be discussed or released without your written consent documented on a release of information form. The following exceptions are noted:

- The EAP Counselor believes that you might harm yourself or someone else. This may include information indicating impairment severe enough to pose a life-threatening situation in the workplace.
- The EAP Counselor believes that a child, an elderly person or a disabled person is being abused and/or neglected.
- A court order is issued requiring the EAP to provide information in connection with certain legal proceedings such as child custody, care and protection cases, adoption proceedings, or a case against an EAP Counselor.
- **If your employer has formally referred you for EAP services, the EAP is expected to confidentially inform the referral source as to your participation in EAP and your cooperation with the EAP service plan. Some employers require additional information, especially in cases related to referral based on substance use.** To permit the EAP to provide any information to your employer, you will need to sign a release of information form permitting the disclosure of that information. Only your participation, cooperation and other required information will be released. Your personal problems will not be discussed with the referral source unless you request, in writing, that this be done.
- The EAP Counselor will disclose information and records to Optima EAP as required for coordination of EAP services, quality assurance and/or payment for services provided to you.

I have read the Optima EAP Statement of Understanding including the confidentiality of the EAP and the limitations to confidentiality. Any questions about this Statement have been answered, and I understand its contents and accept it as the terms of my participation in EAP.

I release and agree to hold harmless Sentara Healthcare, Optima Behavioral Health, Optima EAP and their staff, employees and agents from any action or liability arising out of my participation in the EAP.

_____

Date

_____

Signature of Client (Typed Name Represents an Electronic Signature)

_____

Signature of parent or guardian if client is a minor

*Name*_____ *Date*_____

For questions 1 – 9, please think about your experience in the past two weeks. Check the appropirate box.	Not At All 0	A Little 1	Some Times 2	Alot 3
Little interest or pleasure in doing things.	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling asleep or staying asleep or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you are a failure or that you have let yourself down or your family down	☐	☐	☐	☐
Trouble concentrating on things such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way.	☐	☐	☐	☐
Add Columns				
Total Score of All Columns				

For questions 10 - 13, please think about your experience in the past two months. (Please check the appropriate box.)	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I feel good about myself.	☐	☐	☐	☐
I can deal with my problems.	☐	☐	☐	☐
I am able to accomplish the things I want.	☐	☐	☐	☐
I have friends/family I can count on for help.	☐	☐	☐	☐

1. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor	
2. Indicate if you have a serious or chronic medical condition: ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Chronic Pain ☐ Other – please list:	
3. List any medications you are taking.	
4. In the past 6 months, how many times did you visit a medical doctor?	☐ None ☐ 1 ☐ 2 - 3 ☐ 4+
5. In the past month, how many days has your ability to function been affected by your physical or mental health?	
6. In the past week, approximately how many times have you used alcohol or drugs?	
7. In the past month have you felt that you ought to cut down on your drinking or drug use?	☐ yes ☐ no
8. In the past month have you felt annoyed by people criticizing your drinking or drug use?	☐ yes ☐ no
9. In the past month have you felt bad or guilty about your drinking or drug use?	☐ yes ☐ no
10. In the past month have you needed to have a drink or use drugs to get going in the morning?	☐ yes ☐ no

SUBMIT