Initial Assessment

Please submit this page to the assigned case manager once assessment is completed to get additional sessions authorized.

Perspectives File#: _____ **Affiliate Name:** _____

Client's Last Name: _____ **Client First Name:** _____

Client Presenting Problem

Relevant Client & Family Information

Drug/Alcohol Assessment

Current Use and Pattern/Last Used/Amount:_____

Withdrawal Symptoms: _____

History of Attempts to Control Use: _____

History of Treatment: _____

Related consequences of Drug/Alcohol abuse:

☐ Job ☐ Legal Problems/DUI ☐ Marital/Family/Relationship ☐ Health/Medical ☐ Financial Problems ☐ Health Problems

Comments Related to the above: _____

Motivation for Treatment: _____

Risk/Safety Assessment

Suicidal or Homicidal Thoughts or Plan:_____

If has a plan, access to plan? _____

_____

History of Attempts: _____

Self-Injury or Self-Harm: _____

Mental Health Assessment/Medications

History of Mental Health: _____

Past or Current Prescription Medications (dosage and length of time taken): _____

Initial Treatment Goals

Follow-Up Appointments

Please submit this page to the assigned case manager for any sessions authorized beyond the initial assessment to get additional sessions authorized, if needed.

Perspectives File#: _____	**Affiliate Name:** _____
Client's Last Name: _____	**Client First Name:** _____

Focus/Intervention During Session

Counselor's Assessment & Client's Response During Session

Progress Towards Treatment Goals

Client Assessment Summary and Case Closing Form

Perspectives File#: _____ **Affiliate Name:** _____

Client's Last Name: _____ **Client First Name:** _____

Assessed Problem 1

☐ Academic Stress	☐ Anxiety	☐ COVID-19 Related	☐ Financial	☐ Occupational	☐ Traumatic Stress
☐ Addiction	☐ Behavioral/Conduct	☐ Depression	☐ Grief/Loss	☐ Professional Conduct	☐ Work Stress
☐ Addictions Family	☐ Child Care	☐ Domestic Violence	☐ Housing	☐ Psych/Emotional	☐ Work/Life Balance
☐ Adjustment Issues	☐ Conflict with Co-Worker	☐ Drugs	☐ Legal	☐ Relationship	
☐ Alcohol	☐ Conflict with Supervisor	☐ Elder Care	☐ Marital	☐ Sexual Assault	
☐ Anger Management	☐ Convenience Search	☐ Family	☐ Medical	☐ Stress	

Assessed Problem 2

☐ Academic Stress	☐ Anxiety	☐ COVID-19 Related	☐ Financial	☐ Occupational	☐ Traumatic Stress
☐ Addiction	☐ Behavioral/Conduct	☐ Depression	☐ Grief/Loss	☐ Professional Conduct	☐ Work Stress
☐ Addictions Family	☐ Child Care	☐ Domestic Violence	☐ Housing	☐ Psych/Emotional	☐ Work/Life Balance
☐ Adjustment Issues	☐ Conflict with Co-Worker	☐ Drugs	☐ Legal	☐ Relationship	
☐ Alcohol	☐ Conflict with Supervisor	☐ Elder Care	☐ Marital	☐ Sexual Assault	
☐ Anger Management	☐ Convenience Search	☐ Family	☐ Medical	☐ Stress	

Recommendation/Referral

☐ Community Mental Health	☐ Inpatient Alcohol/Drug	☐ Medication Management	☐ Psychiatric Day Hospital
☐ Community Resource	☐ Inpatient Psychiatric	☐ Outpatient Alcohol/Drug	☐ Psychiatric Evaluation
☐ EAP Problem Resolution	☐ Intensive Outpatient Alcohol/Drugs	☐ Outpatient Individual	☐ Self-Help Group
☐ EAP Short Term Counseling	☐ Intensive Outpatient Program	☐ PCP	
☐ Education – Substance Abuse	☐ Medical Evaluation	☐ PHP Alcohol/Drug	

Outcome

☐ Problems resolved entirely	☐ Referrals accepted using insurance	☐ Referrals accepted to community resources
☐ Client(s) did not complete services		

Client File #: _____

Participant Statement of Understanding

To our Participants:

Perspectives is a voluntary service provided to you and your family as an employee benefit. Before we begin your assessment for services, there are several aspects of the program we would like to review.

Perspectives provides assessment, referral, follow-up, and depending upon the session model which your company has chosen, short-term counseling and/or case management. There is no cost to you for any services provided by Perspectives. At the start of services, you will complete an initial assessment with a counselor. The counselor will assess if you will benefit from short-term counseling through the program or if you would be better served by being referred to a clinician for long-term counseling.

If it is determined that you will benefit from short-term counseling, you will be authorized further sessions through the program. The number of sessions is determined based on clinical appropriateness and the service contract your company has purchased.

If it is determined that you will benefit from long-term counseling, then the counselor will provide you with referrals through your insurance benefit (this may or may not include an option to continue with the counselor you have been seeing through Perspectives). It is important to note that while short-term counseling is provided free through Perspectives, any referrals that involve the use of insurance may result in a cost to you.

When a problem requires specialized or longer-term services, a referral may be made after the initial assessment. If you are referred, there may be fees involved for the specialized or longer-term services. Those services may be covered under the insurance benefits provided by your employer; however, it is your responsibility to determine whether the cost of those services is covered by your insurance benefits. It is your responsibility to verify your eligibility through your insurance vendor, which includes information around deductibles, lifetime maximum, and pre-existing conditions.

Sharing your personal information may be difficult and we want to assure you of our efforts to maintain your privacy. Perspectives and/or its affiliate services are strictly confidential as mandated by state and federal laws. No information regarding the nature of the problem can be released without your expressed written consent. Lawful release of records is permitted for cases of child, elder or disabled adult abuse or if you pose a threat of imminent danger to yourself or others. Perspectives must also release records if court ordered or in instances where a lawsuit is filed against Perspectives.

If you need to cancel an appointment, call your counselor 24 hours prior to your scheduled time. If circumstances prevent this, please call your counselor to discuss the situation.

Should your supervisor or human resource representative initiate services due to job performance concerns, neither the nature of the problem nor specifics about the recommendation will be disclosed unless you permit it with a written release of information. In instances where Perspectives is required to make a recommendation relative to your fitness to return to work, such a recommendation may be withheld if Perspectives is unable to fully disclose information due to not having your signed consent.

I have read and understand this Statement of Understanding.

Signature of Client	**Witness**
Printed Name of Client	**Date**

Notice of Privacy Practices

(Two Pages)

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. **You may obtain a copy of this** policy and your privacy rights notice from your counselor at any time upon request. We ask that you sign a copy of the statement of rights (next page).

Perspectives, and its affiliated network providers located in and outside of the United States, respect patient confidentiality and only release medical information about you in accordance with federal and state laws. This notice describes our policies related to the use of the records of your care generated by Perspectives, Ltd. If you have any questions about this policy or your rights contact Perspectives' Privacy Officer.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your medical information with others beyond our practice, for purposes of:

Treatment: To provide, coordinate, or manage your care or any related services, including sharing information with others outside our practice that we are consulting with or referring you to.

Payment: To obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations: To coordinate our business activities. This may include setting up your appointments, reviewing your care, and supervising our staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

PATIENT PRIVACY RIGHTS

You have the following rights under state and federal law:

Copy of Record. You are entitled to inspect the healthcare records our practice has generated about you. We may charge you a reasonable fee for copying and mailing your records.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the medical information. This request must be in writing. The Practice is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Perspectives' Privacy Officer.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable, and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will be glad to provide you information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact Perspectives' Privacy Officer and ask for the *Request to Amend Health* Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement that you disagree with us. We will then file our response and your statement, and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to Perspectives' Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions or wish a copy of this Policy or have any complaints, you may contact Perspectives' Privacy Officer in writing at our office further information. You also may complain to the Secretary of Health and Human Services if you believe our Practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. The Practice reserves the right to change its Privacy Policy based on the needs of the Practice and changes in state and federal law.

Acknowledgement of Privacy Rights and Consent for Disclosure of Protected Health Information between Affiliate Provider and Perspectives, Ltd.

I acknowledge receipt of and understanding of my privacy rights in connection with Perspectives. I further authorize Perspectives, Ltd. and

_____

(Affiliate and/or local organization providing services on behalf of Perspectives)

to exchange written and verbal information about my (my family's) employee assistance services including assessment information, needs, impressions, counseling recommendations, referrals, dates of service, and contact(s) with other parties in connection with treatment, payment, and service operations.

_____ _____

Signature(s) of adult client(s) **Date**

Perspectives' Affiliate Provider will retain a copy of this notice with your signature in their records. A copy will also be provided to you upon request.

Consent for Release of Confidential Information

(only needed if a supervisory referral)

I _____ (Name of Client), voluntarily consent to and authorize the following releases of information.

Section I

I authorize Perspectives to disclose and release to the following individuals or organizations:

_____

All information needed to:

- ☐ refer client for treatment
- ☐ have services authorized
- ☐ obtain benefit coverage or payment for services
- ☐ help in planning, providing or monitoring services
- ☐ other _____

Section II

I authorize _____ (Service Provider) to disclose and release to Perspectives all information needed to help manage or coordinate my case.

Mental Health Assessment/Medications

I authorize Perspectives to disclose and release to representative of my employer:

_____

_____

(Name of supervisor or employer representative)

the following information:

- ☐ I have kept appointments with the counselor
- ☐ The recommendations regarding level of service
- ☐ Referral to outside resources when appropriate
- ☐ My compliance with and/or completion of the recommendations
- ☐ other _____

I understand that I have the right to inspect any written information to be disclosed. I understand that if I do not consent, the information sought to be disclosed will not be disclosed except as provided by law. My consent is subject to revocation in writing at any time, but such revocation can have no effect on disclosures already made. In any event, this authorization expires without express revocation one year from the date which appears below.

Notice: No person or company to whom any information is disclosed pursuant to this authorization may redisclose such information unless the person who authorized this disclosure specifically consents to such disclosure.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing mental health, substance abuse or AIDS related information under the Federal Substance Abuse Confidentiality Requirements, the Illinois Mental Health and Developmental Disabilities Confidentiality Act and the Illinois AIDS Confidentiality Act.

I also understand that the person I am authorizing to use the information may receive compensation for doing so. I understand that I may inspect and copy the information disclosed. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

NOTE TO RECEIVING AGENCY/PERSON: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). 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 42 CPR, 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient. State law regarding the confidentiality of mental health records also prohibits redisclosure of this information without the specific consent of the person who consented to the disclosure

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date

TELEHEALTH CONSENT

I _____ (the “Client”), have requested that _____ (the “Counselor”), _____ (license type) and Perspectives, Ltd., an Illinois corporation (“Perspectives”) communicate and provide EAP services to me using internet-based communication programs, such as Zoom.

In communicating with Counselor using internet-based communication programs, I understand, acknowledge, and agree to the following:

1. I understand that Perspectives has invited me to engage in a telehealth appointment/consultation to provide assessment and short-term counseling.
2. A Perspectives representative has explained to me that video conferencing technology will not be the same as a direct client/counselor visit due to the fact that I will not be in the same room as my counselor.
3. I understand that there are risks associated with use of this technology such as:
    a. Interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my problem, and that all possible precautions will be taken to minimize these risks. In addition, my counselor or I can discontinue the telehealth visit if it is felt that the information obtained through the telehealth connection is not adequate for decision-making or for implementing management of my issue(s).
    b. In very rare instances, security protocols could fail, causing a breach of privacy of personal information. In that event, we will complete the session by phone or if available, schedule an in-person appointment at the location where adequate assessment and short-term counseling can be provided.
4. I understand that the information I provide may be shared only with other individuals at Perspectives for scheduling purposes.
5. The alternatives to a telehealth appointment/consultation (if applicable) have been explained to me.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me.
- I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment/consultation.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date