

## STATEMENT OF UNDERSTANDING

Case # \_\_\_\_\_

You have voluntarily chosen to use the benefit provided by your Employee Assistance Program (EAP).

You are eligible for up to \_\_\_\_\_ sessions with your counselor. However, the number of sessions received will be based on clinical need and is to be determined by you and your counselor. If your reason for contacting EAP cannot be adequately addressed within the allotted number of sessions, you will be referred out of EAP for further assistance. This referral typically occurs between sessions 2 (two) and 3 (three).

This EAP program is provided to you at no cost. However, you may incur costs if you are referred to a treatment provider when deemed appropriate following the assessment by the EAP counselor. Any referrals will be made with careful consideration of your insurance benefits and economic situation.

The EAP program is a confidential service. Information disclosed during your counseling session will only be communicated outside of the EAP under the following circumstances: 1) you consent in writing; 2) your life or safety is seriously threatened; 3) the life or safety of others is seriously threatened; 4) disclosure is required by law; and/or 5) there is an admission of child abuse.

I, (name) \_\_\_\_\_ understand the information printed above and will participate in the EAP program under the terms specified above.

\_\_\_\_\_  
Signature (client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (counselor/witness)

\_\_\_\_\_  
Date