REACH
Employee Assistance & Work Life Services

Statement of Understanding & Consent Form

REACH is your **Employee Assistance Program – EAP** contracted by your employer to provide confidential assistance for you and your family. **REACH** counselors will help you in three sessions or less with problem assessment, short-term counseling, and referral services.

REACH is a pre-paid company benefit for you and your dependents, so there is no cost to you. Should you need assistance beyond that of **REACH**, you will be responsible for any charges incurred. Your counselor will always discuss that cost with you before making a referral. In many cases your insurance plan may pay for some or all of these costs.

Law and professional codes guarantee confidentiality. All information given during the course of counseling and by phone will be kept completely confidential. The only exceptions are when you give written permission or when required by law (i.e. child abuse, dependent-adult abuse, domestic violence, or probable bodily harm to self or others). Also, we are providing you with a copy of **Notice of Privacy Practices**, which describes how this organization is required by federal law to maintain and protect the privacy of your health information and is obliged to render information to you with your consent as mandated by HIPAA (Health Insurance Portability and Accountability Act).

We know how difficult it can be to ask for help with anything. You can be assured that we will do our best to serve you in a timely and professional manner. If you have additional questions please ask your counselor, we are here to help. Thank you.

For the purpose of follow-up and scheduling future appointments, **REACH** staff with discretion may contact me at the following:

Home # _____ Work # _____

Address:_____
City:_____ State: _____ Zip:_____

I have read the above information and the **Notice of Privacy Practices**, and consent for the **REACH** staff to render services.

_____

Print Name _____

Signature Name _____ Date _____

Witness _____ Date _____

1-800-273-5273 * info@reachline.com

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CONSENT TO RELEASE INFORMATION

I, (Last Name) _____ (First Name) _____

I authorize REACH staff associates and/or its affiliate's, specifically:

Name(s)_____

to release the following:_____

Supervisor / Company Personnel:
Name(s)_____

Information to be released: _____

Therapist / Treatment Program / Referral: SS / DOB
Name(s)_____

Information to be released:_____

Family member:
Name(s)_____

Information to be released:_____

I agree that the above consent is only valid for six months or to _____/_____/_____.

Signature of client _____ Date ____/____/_____

Signature of witness / parent / guardian) _____ Date ____/____/_____

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