MAZZITTI & SULLIVAN

NOTICE OF PRIVACY PRACTICES (NPP) SUMMARY

This notice is a summary of how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment to your privacy

Mazzitti & Sullivan EAP is dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. These laws are complicated, but we must provide you with important information. This page is a shorter version of the full, legally required NPP (Notice of Privacy Practices) that is available to you. If you desire a copy, one will be provided at your request. However, since we can't cover all possible situations, please talk to our Privacy Officer (shown at the bottom of this page) about any questions or problems.

We will use the information about your health that we get from you or from others mainly to provide you with **treatment,** to arrange **payment** for our services, or for some other business activities that are called, in the law, health care **operations.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, the counselor cannot treat you.

If you or we want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help, prevent, or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Worker's Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for you care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it on our website, www.mseap.com, and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please ask.

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EMPLOYEE ASSISTANCE PROGRAM

INFORMATION AND CONSENT FORM

The evaluation and referral service of the Employee Assistance Program is confidential and all information obtained will be kept as such unless we receive your expressed written consent. Exceptions are outlined in the Notice of Privacy Practices (NPP). All activities conducted by Mazzitti and Sullivan EAP services adhere to HIPAA Privacy Practice compliance guidelines. Your signature below acknowledges your receipt of our NPP and grants us permission to use and disclose your protected health information (PHI) as necessary for treatment, payment to the provider, and basic mental health care operations.

The Employee Assistance Program (EAP) provides a free evaluation and short term counseling services; therefore, you are not obligated to make any payment to the evaluator for the EAP sessions. If continued treatment is recommended beyond what is provided by the program, the EAP evaluator will assist you in finding the most appropriate services and will help you in determining the cost of treatment and how it relates to your benefit plan.

The EAP services provided to you include case management and follow-up to insure that you are receiving satisfactory services and to perform quality assurance functions. We will contact you by phone one month, three months, six months, and twelve months after counseling is completed unless you request otherwise. The purpose of the contact will be to assess the quality of the services provided to you in order to allow us to supply our clients with services that are effective and beneficial to their well-being. This information is confidential and will not be shared with anyone without your consent.

If you need to contact the EAP at any time, you may call: 1-800-543-5080.

Having reviewed the above information, I hereby consent to the services provided by the Employee Assistance Program. I realize my participation is voluntary and will be kept confidential.

_____ _____

Employee/Client Signature Date

_____

Client's Name (Print)

_____ _____

Witness Signature Date

I do give consent to be contacted for a follow-up. Yes ❒ No ❒

Best phone number/times to reach you _____

May we leave a message/voicemail? Yes ❒ No ❒

This form must be completed at the initial evaluation/assessment and sent to the EAP.

479 Port View Drive, Suite C-30, Harrisburg PA 17111 * 1-800-241-5740
Fax: 717-901-5659 Email: **info@mseap.com**

MAZZITTI & SULLIVAN

EVALUATION INITIAL REPORT FORM

Date: _____ Counselor: _____ Diag. Code: _____

Client Name: _____ Home #: _____

Address: _____ S.S. #: _____

_____ Marital Status: _____

Sex: Male ❒ Female ❒ D.O.B.: _____

Client Type: Employee ❒ Family Member ❒

Client Referred By: Self ❒ Family ❒ HR/Supervisor ❒ Mandated ❒

Health Insurance Co.: _____ Insured's Name: _____

EAP COMPANY EMPLOYEE INFORMATION

Name of Employee: _____ Name of Employer: _____

Job Classification: _____ Length of Service: _____

Work Phone: _____ Work Hours: _____

COUNSELOR'S USE ONLY BELOW THIS LINE!

PRIMARY PROBLEM TYPE (CHECK ONLY **ONE** PLEASE)

Emotional/Personal: ❒ Family/Marital: ❒ D/A: ❒ Vocational: ❒ Health Related: ❒

Other (Specify): _____

This form must be completed at the initial evaluation/assessment and sent to the EAP.

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SUMMARY REPORT FORM

To be returned after the last authorized EAP session, or 2 months without any session (whichever comes first).

Evaluator Name/Agency: _____

Client Name: _____ Employer's Name: _____

Date of First Appointment: _____ Date of Final Appointment: _____

Total # of EAP Sessions used: _____

Notes: _____

_____

_____

_____

_____

TREATMENT RECOMMENDATIONS/REFERRALS:

Names/Locations

Inpatient/Hospital _____

Outpatient Therapy _____

Self Help Group _____

Financial/Legal Counseling _____

Community Resources _____

Check here if no referral/recommendation (Used EAP Sessions ONLY) ❒

Does the client accept any of the recommendations/referral(s)? Yes ❒ No ❒

If Yes, which recommendation(s)? _____

Was the client connected to the agency referred to for appointment? Yes ❒ No ❒ N/A ❒

Evaluator Signature: _____ Date: _____

Please complete and return to the EAP within two months after the final EAP session.

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EMPLOYEE ASSISTANCE PROGRAM (EAP) INVOICE

TODAY'S DATE:

This invoice is for the following session(s) performed in the office:

DATE OF SERVICE	CLIENT NAME	EVALUATOR	VISIT#

*Please note that invoices submitted after one year from the client's final EAP visit will not be accepted.

Cost per Evaluation: $60.00 (unless otherwise specified)
Number of Sessions: _____
Total Amount Due: _____

Please make check payable to: _____

Mailing Address: _____
_____
_____

Please submit one invoice per client with your completed EAP Summary Report Form to:

EAP Billing Department
Mazzitti & Sullivan EAP Services, Inc.
479 Port View Drive, Suite C-30
Harrisburg, PA 17111
(800) 241-5740

Please indicate other materials enclosed:

- ❒ Signed Information & Consent Form
- ❒ (Client refused to sign Info & Consent Form)
- ❒ Completed EAP Evaluation Initial Report Form
- ❒ Completed EAP Summary Report Form
- ❒ Other/Specify: _____