Corporate Background

Mazzitti & Sullivan EAP Services is an organizationally separate division of Mazzitti & Sullivan Counseling Services, Inc. The EAP division has its own dedicated staff, phone and computer systems, operating policies and procedures and data management systems and forms. Our main office is located at:

Mazzitti & Sullivan EAP Services
479 Port View Drive, Suite C-30
Harrisburg, PA 17111

Telephone: 800-241-5740
Fax: 717-901-5659
Website: www.mseap.com

Mazzitti & Sullivan Counseling Services, Inc. was established in 1983 and has been developing, implementing, and administering Employee Assistance Programs since 1984. Our history is rooted in outpatient clinical services and clinical professionals lead our operations rather than business school graduates. As a result, our priorities center on patient care, service delivery, and successful outcomes. We have found that by concentrating on these areas, our business has grown, our reputation has grown, and we encounter an increasing number of opportunities for success. We believe that patient care and a commitment to customer service will produce the results sought by the managed care arm of the health insurance industry. Our commitment to patient care has led us to develop numerous Employee Assistance Program models for our corporate clients. This same commitment is evident in our other lines of service as well. The development of intensive outpatient programs, student assistance services, and wrap-around counseling for children and adolescents all grew out of our commitment to address the needs of our patient population. In the area of employee assistance, we have experienced steady growth over the years, and today our agency manages approximately 80 different EAP and managed behavioral health care contracts. These contracts provide services to approximately 325,000 covered lives at more than 400 work sites in Pennsylvania and across the nation.

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RESPONSIBILITIES OF THE EVALUATOR & REFERRAL PROTOCOL

1) The Evaluator will receive a referral (by phone, mail, or fax) from a representative of Mazzitti & Sullivan EAP Services. The EAP Account managers are the evaluator's point of contact at the EAP, and any account manager can provide assistance. In most cases, the client will contact the Evaluator to schedule an appointment. There are times, however, when the evaluator will be instructed to call the client.

2) The Evaluator will schedule a face-to-face evaluation with the client, preferably within three (3) working days from the time of initial contact. Exceptions to this timeframe pertain to holidays, vacation, or specific requests for a certain counselor or evening appointment. If the Evaluator is unable to schedule the client within this timeframe, and the client is willing to wait, we would not consider you in breach of contract. If the client does not wish to wait, he or she is welcome to call Mazzitti & Sullivan back and obtain a referral to another agency. If the client requests an appointment beyond three working days, the evaluator should proceed with scheduling and inform the EAP account manager of the client's preference and appointment information.

3) If the client requires an emergency evaluation, the evaluator needs to schedule an appointment to be held with 24 hours of the initial contact. **If the evaluator cannot schedule the emergency appointment, the EAP account manager must be notified immediately.**

4) The evaluator will contact the EAP account manager to confirm the date and time of the scheduled evaluation. During non-business hours, call the 800 number and specify that you want to leave a message of a routine nature; then give the client name and relevant appointment information.

5) Prior to the evaluation session, the evaluator should explain the **EAP Information and Consent Form** to the client(s). Explain to the client that his/her signature on this form is necessary for you (evaluator) to receive payment for the session(s) as well as to give permission to release necessary information back to the EAP account manager. ***It is not a consent to release information to the employer or other outside party.*** Clients must sign the **EAP Information and Consent Form** if they are to receive services through the EAP. The client may sign this form but choose not to be contacted for follow-up by the EAP. They may leave this bottom area blank if they so choose. <u>If the client refuses to sign the form, the evaluator will inform the client that the evaluation cannot take place and that the client will not be able to utilize EAP benefits.</u> At this point, terminate the session and promptly notify the EAP account manager. In this situation, the EAP **will** pay you for the session. Submit the **EAP Invoice** to the EAP and check the box at the bottom indicating "(client refused to sign Info & Consent Form)."

6) After the initial evaluation, the evaluator will submit the **EAP Information and Consent Form** and the **EAP Evaluation Initial Report Form** to Mazzitti & Sullivan EAP Services.

7) Upon completion of the EAP-authorized session(s):
   a) If the evaluator does not recommend continued treatment for the client beyond the authorized EAP sessions, complete the **EAP Summary Report Form** and check the box indicating that the client used EAP Sessions ONLY.
   b) If the client is being referred for additional services, the evaluator should provide the client with at least two (2) referral options (the evaluator may self-refer if appropriate). In presenting the options, evaluator needs to consider the client's ability to pay.
   c) If the evaluator recommends alcohol, drug, mental health and/or psychiatric services beyond the EAP sessions, he/she must utilize appropriate placement criteria to determine the level of treatment.
      1. If the client has insurance, refer the client, as appropriate, to an in-network provider, Gatekeeper, or Primary Care Physician. Self-referrals are permitted, if appropriate.
      2. If uninsured, utilize the local county drug and alcohol or community mental health system; refer to a local agency which works on a sliding fee scale; or, refer as self-pay, providing information about the costs related to this option.

8) The Evaluator will assist the client in contacting and arranging an appointment with the agency to which the client is referred.

9) If the client has not contacted the evaluator for sixty (60) days or more, and has not used all of his or her authorized EAP sessions, please discharge the client and complete the **EAP Summary Report Form.** This information is only used for statistical reporting purposes, as well as follow-up with the client.

10) The Evaluator agrees not to contact a client's employer and/or supervisor without consulting and receiving the approval of Mazzitti & Sullivan EAP Services, as well as written consent from the client.

11) The evaluator must consult with the EAP staff member if unusual circumstances or problems occur with the client and/or referral process.

12) The Evaluator will submit the **EAP Information and Consent Form** and the **EAP Evaluation Initial Report Form** immediately following the initial session.

13) The **EAP Invoice** may be submitted via fax to 717-901-5659, emailed to info@mseap.com, or mailed to the following address. Please note that invoices submitted after one year from the client's final EAP visit will not be accepted.

Mazzitti & Sullivan EAP Services
479 Port View Drive, Suite C-30
Harrisburg, PA 17111

If you have any questions about this process, please call the EAP administrative office at 1-800-241-5740.

14) The Evaluator agrees to accept **the agreed upon sum as full payment for each evaluation session**. The client should **not** be charged for services rendered as part of the EAP referral.

LIABILITY

Hold Harmless Clause—The Evaluator agrees to indemnify, defend and save harmless Mazzitti & Sullivan EAP Services, their partners, agent and employees, for any and all claims and losses accruing or resulting to any and all contractors, their employees and/or agents, and any other persons involved in the performance of this agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Evaluator in the performance of the agreement.

The Evaluator will indemnify Mazzitti & Sullivan EAP Services and hold them harmless from any and all losses, claims, attorney fees, cost or damage resulting from any:

A) Breach of the agreement by the Evaluator;
B) Professional error or omission by the Evaluator or its employees, servants, agents, contractors or Board of Directors;
C) General public liability claims arising in connection with business or the business activities of the Evaluator, which pertains to the agreement.

Mazzitti & Sullivan EAP Services also agrees to hold the Evaluator harmless in return.

Covenant Against Referral Fees or Fee Splitting—The Evaluator agrees that no employee, board member or representative of a Treatment Agency, either personally or through an agent, shall solicit the referral of clients to any facility in a manner which offers or implies an offer or rebate or fee-splitting inducements to persons referring clients. This applies to contents of fee schedules, billing methods or personal solicitation. No person or entity involved in the referral of clients may receive payment or other inducement by a facility or its representatives.

This agreement shall not be construed as creating an Employer/Employee relationship between Mazzitti & Sullivan EAP Services and the contractor. The Contractor Evaluator shall, for all purposes, be an independent contractor responsible for all taxes, insurance and licenses as required.

The Evaluator agrees to carry current liability insurance in the amount equal to or in excess of $1,000,000.00 per occurrence (combining policies is permitted), which shall cover all risks pertinent to this agreement. The Evaluator shall provide Mazzitti & Sullivan EAP Services with a copy of the front page of the said policy within 30 days of this agreement, as well as when the policy is revised or renewed.

REIMBURSEMENT & PROCEDURE

Mazzitti and Sullivan shall be responsible for initiating contact (referral) to the Evaluator, and for receiving forms and information following evaluation and referral and for providing follow-up contacts with the client(s) and, where appropriate, with the supervisor(s).

Reimbursement shall occur on a monthly basis, provided all reports are appropriately submitted. The Evaluator may use the EAP Invoice Form to bill Mazzitti & Sullivan EAP Services for the evaluation(s) performed (one invoice per client). HCFA forms are also acceptable.

Mazzitti & Sullivan EAP Services

LETTER OF UNDERSTANDING

This **Letter of Understanding** is between _____
(evaluator name – please print)

of _____ and Mazzitti & Sullivan EAP Services.
(agency name)

This document establishes:
1) Responsibilities of the evaluator
2) Reimbursement rate ($60) and procedures

This **Letter of Understanding** begins on the effective date of approval by both parties and is not limited by time. Either party may terminate this arrangement at any time, for any reason.

Nothing contained within this document should be construed to imply that any number of referrals will be made by Mazzitti & Sullivan EAP Services to the local evaluator. Mazzitti & Sullivan EAP Services reserves the right to determine whether any particular client will be referred to any particular evaluator.

_____ _____
Agency Director (or other authorized agency personnel) Date

_____ _____
Evaluator signature Date

_____ _____
Mazzitti & Sullivan EAP Services Representative Date

*Please return via fax or mail to Mazzitti & Sullivan EAP Services and retain a copy for your records. Each counselor who is willing to work with Mazzitti & Sullivan **must** complete a separate Letter of Understanding.*

COUNSELOR INFORMATION

Each counselor who wishes to participate in the EAP must fill out this form and return to the address below with a signed copy of the Letter of Understanding, a copy of your state-issued license, W-9 form, and liability information.

1) Full Name: _____

2) Degree (highest completed):

❑ PhD ❑ Masters ❑ Bachelors ❑ Other_____

3) Discipline:

❑ Psychologist ❑ Social Worker ❑ Minister

❑ Psychiatrist ❑ Addictions Counselor ❑ Marital/Family

❑ Other (please specify) _____

4) If you cannot attach a copy of your current state-issued license, please explain why:

_____

_____

5) Patient groups (check all that you personally are willing to counsel):

❑ Individuals ❑ Couples ❑ Families

❑ Children/Teens/Adults (list age range) _____

6) Do you have any specialties?

❑ Marital/Family ❑ Addictions ❑ Christian Counseling

❑ Parenting ❑ Children of Alcoholics ❑ ADD/ADHD

❑ Playtherapy ❑ Gay/Lesbian issues ❑ Hypnosis

❑ Men's issues ❑ Women's issues ❑ Stress/Anxiety/Grief

❑ Mood disorders ❑ Geriatrics (over 65) ❑ Spanish-speaking

❑ Other (please list): _____

_____

7) If your agency has more than one location, where do you practice? List days and hours.

_____

_____

8) Are you CISD trained? ❑ Yes ❑ No

9) Are you a certified Substance Abuse Professional (SAP) qualified to provide assessments for CDL drivers accused of drug/alcohol related violations (not including DUI/DWI)? ❑ Yes ❑ No

AGENCY INFORMATION

Please list information on your agency as a whole and return to the address listed below with the necessary documentation.

1) Agency/Group name: _____

2) Private Practice? ❑Yes ❑No

3) Main office address: _____

_____ County: _____

4) Main telephone # of practice: _____

5) Main fax # of practice: _____

6) E-mail (if applicable): _____

7) Do you have any clinicians on staff who are trained to do CISD (Critical Incident Stress Defusing/Debriefing) and would be able to assist us in an emergency situation?
❑Yes ❑No

8) Do you have any clinicians on staff who are trained as a Substance Abuse Professional (SAP) and can provide assessments for CDL-related violations? *These evaluations are <u>not</u> covered under EAP.*
❑Yes ❑No

9) Please list contact information for your agency if we have any questions or concerns.

Name/Title _____

Phone _____ Extension _____ Fax _____

10) Please list any additional offices your practice maintains. (Use a separate sheet if necessary.)

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

11) If you have more than one location, referrals should be directed to:

❑ Main office number ❑ Individual office where client will be seen

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.

Mazzitti & Sullivan EAP Services – Notice of Privacy Practices

(Full version)

Privacy is a very important concern for all those who contact our EAP. It is also complicated because of federal and state laws and our professional standards. Because the rules are so complicated some parts of this Notice are quite detailed and you may need to read them several times to understand them. If you have any questions, our Privacy Officer will be happy to help you. His name and address are at the end of this Notice.

Contents of this Notice

A. Introduction to our clients

This Notice will tell you about how we handle information about you. It tells how we use this information in our office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. We are also required to tell you about this because of the privacy regulations of a Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Because this law and the laws of this state are very complicated and we don't want to make you read a lot that may not apply to you, we have simplified some parts. If you have any questions or want to know more about anything in this Notice, please ask our Privacy Officer for more explanation or more details.

B. What we mean by your medical information

Each time you contact us (or any other health care provider), information is collected about you and your mental health. It may be information about your past, present, or future health or conditions, or the treatment or other services you got from us or from others, or about payment for health care. The information we collect from you is called, in the law, **Protected Health Information (PHI).** This information goes into your **medical or health care record** or file at the counselor's and our office. In our office the PHI is likely to include these kinds of information:

- Personal information – your name, Social Security Number, address, phone numbers, and place of employment (for statistical reporting ONLY).
- Reasons you came for treatment – your problems, complaints, symptoms, needs, and goals.
- Diagnoses – the medical terms for your problems or symptoms.
- A treatment plan – the treatments and other services that your counselor thinks will best help you.
- Progress notes – each time you come in, your counselor writes down some things about how you are doing, what he/she observes about you, and what you tell him/her.
- Records we get from others who treated or evaluated you.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information.

This list is just to give you an idea, and there may be other kinds of information that go into your health care record here.

We use this information for many purposes. For example, we may use it:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional to whom we referred you.
- For teaching and training of other health care professionals.
- For public health officials trying to improve health care in this country.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about whom, when, and why others should have this information.

Although your health record is the physical property of the health care practitioner or facility that collected it, the information belongs to you. You can inspect, read, or review it. If you want a copy we can make one for you, but we may charge you for the costs of copying (and mailing if you want it mailed to you). In some very unusual situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect, or something important is missing, you can ask us to amend (correct or add information to) your record, although in some rare situations we don't have to agree to do that. Our Privacy Officer, Andrew T. Sullivan, can explain more about this.

C. Privacy and the laws

The HIPAA law requires us to keep you PHI private and to give you this Notice of our legal duties and our Privacy Practices, which is called the **Notice of Privacy Practices** or **NPP.** We will obey the rules of this Notice as long as it is in effect, but if we change it the rules of the new NPP will apply to all of the PHI we keep. If we change the NPP, we will post the new Notice in our office where everyone can see it. You or anyone else can also get a copy form our Privacy Officer at any time, and it will be posted on our website at www.mseap.com.

D. How your protected health information can be used and shared

When your information is read by anyone in our office or your counselor's office that is called, in the law, **"use."** If the information is shared with or sent to others outside this office, that is called (in the law) **"disclosure."** Except in some special circumstances, when we use your PHI here or disclose it to others we share only the **minimum necessary** PHI needed for the purpose. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed, and so we will tell you more about what we do with your information.

We use and disclose PHI for several reasons. Mainly, we will use and disclose (share) it for routine purposes and we will explain more about these below. For other uses, we must tell you about them and have a written Authorization from you, unless the law lets or requires us to make the use or disclosure without your authorization. However, the law also says that we are allowed to make some uses and disclosures without your consent or authorization.

1. Uses and disclosures of PHI in health care *with* your consent

After you have read this Notice, you will be asked to sign a separate **Consent form** to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for services provided to you, or some other business functions called health care **operations.** Together these routine purposes are called TPO and the Consent form allows us to use and disclose your PHI for TPO.

a. For treatment, payment, or health care operations

We need information about you and your condition to provide care to you. You have to agree to let us collect the information, use it, and share it as necessary to care for you properly. Therefore you must sign the Consent form before your counselor begins to treat you, because if you do not agree and consent he/she cannot treat you.

When you come to see your counselor, several people in that office may collect information about you and all of it may go into your health care records there and/or in our office. Generally, we may use or disclose your PHI for three purposes: treatment, providing payment, and what are called health care operations.

For treatment

We use your medical information to provide you with psychological treatment or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the effects of our services.

We will need to share or disclose your PHI to others who provide treatment to you. If you are being treated by a team, we can share some of your PHI with them so that the services you receive will be coordinated. They will also enter their findings, the actions they took, and their plans into your record so that they all can decide what treatments work best for you and make up a Treatment Plan. If you receive treatment in the future from other professionals accessed through Mazzitti & Sullivan EAP Services, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment

Your counselor may use your information to bill you, your insurance, Mazzitti & Sullivan EAP Services, or to others to be paid for the treatment provided to you. We (or your counselor) may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and what is expected as you are treated. We will need to tell them about when you and your counselor meet, your progress, and other similar things.

For health care operations

There are some other ways we may use or disclose your PHI, which are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and service we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatments, and make plans for services that are needed. If we do, your name and any other identifying information will be removed from what we send.

b. Other uses in health care

Appointment reminders: Your counselor may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want him/her to call or write to you only at your home or your work, or prefer some other way to reach you, it can usually be arranged. Simply notify us and your counselor of your preferences.

Treatment Alternatives: We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research: We may use or share your information to do research to improve treatments. For example, comparing two treatments for the same disorder to see which works better, faster, or costs less. In all cases, your name, address, and other information that reveals who you are will be removed form the information given to researchers. If they need to know who you are we will discuss the research project with you and you will have to sign a special Authorization form before any information is shared.

Business Associates: There are some jobs we hire other businesses to do for us. They are called our Business Associates in the law. Examples include a copy service your provider may use to make copies of your health record and a billing service that figures out, prints, and mails any bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures *requiring* your Authorization

If we want to use your information for any purposes besides the TPO, or those we described above, we need your permission on an **Authorization Form.** We don't expect to need this very often.

If you do authorize us to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time, we will not use or disclose you information for the purposes that we agreed to. Of course, we cannot take back any information we had already disclosed with your permission or that we had used in our office.

3. Uses and disclosures of PHI from mental health records *NOT requiring* your Consent or Authorization

The laws permit us to use and disclose some of your PHI without your consent or authorization in some cases.

When required by law:

There are some Federal, state, or local laws which require us to disclose PHI.

- We have to report suspected child abuse.
- If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- We have to release (disclose) some information to the government agencies that check on us to see that we are obeying the privacy laws.

For Law Enforcement Purposes:

We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

For public health activities:

We might disclose some of your PHI to agencies that investigate diseases or injuries.

Relating to decedents:

We might disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

For specific government functions:

We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to Worker's Compensation programs, to correctional facilities if you are an inmate, and for national security reasons.

To prevent a serious threat to health or safety:

If we come to believe that there is a serious threat to your health or safety or that of another person or the public we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures requiring you to have an opportunity to object

We can share some information about you with your family or others close to you. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you about whom you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.

If it is an emergency where we cannot ask you if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information in an emergency, we will tell you as soon as we can. If you don't approve, we will stop, as long as it is not against the law.

5. An accounting of disclosures

When we disclose your PHI, we keep some records such as: to whom we sent it, where we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. If you have questions or problems

If you need more information or have questions about the Privacy Practices described above, please speak to the Privacy Officer, whose name and telephone number are listed below. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with us and the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any case limit your care here or take any actions against you if you complain.

Privacy Officer: Nelson Breisch, 1-800-241-5740; email: nbreisch@mseap.com

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 (listed in the full NPP) 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.

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.

479 Port View Drive, Suite C-30, Harrisburg PA 17111 * 1-800-241-5740
Fax: 717-901-5659

MAZZITTI & SULLIVAN

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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.

MAZZITTI & SULLIVAN

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**

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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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Fax: 717-901-5659 Email: **info@mseap.com**

MAZZITTI & SULLIVAN

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: _____