

## New Provider Application

Thank you for your interest in joining Mazzitti & Sullivan EAP Services' Provider Network! We strive to keep our processes simple and our paperwork easy to complete, so that you can focus on what you do best – helping our clients. Please review the following pages for more information about our EAP and what we expect of you as a network provider, then complete and return the following forms to our office:

- **Agency Information Form** – about your practice as a whole
- **Counselor Information Form** – each clinician willing to work with us will need to complete and return this form
- **Letter of Understanding** – each clinician willing to work with us will need to sign this form; if you are a sole practitioner, you may sign both lines
- Copy of each counselor's state-issued **license** and any relevant **certifications**
- **Certificate of insurance for liability coverage** – showing the effective dates, individual/aggregate coverage amounts, and those covered under the policy (for each counselor if they have individual coverage)
- **W-9** – if we reimburse you \$600 or more in a calendar year, you will receive a 1099 form to this address
- **Direct Deposit Form** – for receiving your reimbursements for services

We will notify you if there are any questions or issues with your application, and we will also let you know when you are approved to see our EAP clients. These forms may be emailed or mailed to our office. If at any point you have any questions, please call or email us! Our hours are Monday-Friday, 7:30am-4:30pm, with an answering service after hours to take messages or route urgent issues to our on-call staff member. We respond to emails by the end of the next business day.

### *About Us*

Mazzitti & Sullivan Counseling Services was founded in 1983 by Chuck Mazzitti and Andy Sullivan. In 1984, they created Mazzitti & Sullivan EAP Services in response to a growing need for Employee Assistance Programs in Central Pennsylvania, and incorporated the business in 1990. Throughout the years, our business has grown nationwide, covering public and private employers, for-profits and non-profits alike, and employers of all sizes. We offer a comprehensive EAP benefit to the employers who contract for our services, including counseling, training, and staff development. In 2016, Mazzitti & Sullivan joined Pyramid Healthcare Inc., and the EAP maintains its own headquarters in Harrisburg, PA with its own dedicated staff.

## ***Responsibilities of The Evaluator & Referral Protocol***

- 1) The EAP Network Provider (herein referred to as “Evaluator”) will receive a referral via secure email or e-fax from a representative of Mazzitti & Sullivan EAP Services. This EAP Referral Authorization Form will contain the client’s name, address, phone, date of birth, employer, insurance carrier name, and email (if available). It will also list any other family/household members who may attend sessions with the client, as well as the total number of authorized EAP sessions. An “EAP Code” is provided in the top left corner of the EAP Referral Authorization form, and we use this code as a confidential identifier for the client(s). The code contains primarily letters and numbers, and may also include spaces, dashes, or other characters; if the code ends in a “-1” (or other number), it indicates a family member.
- 2) Occasionally, the EAP client will have already set up the appointment with the Evaluator prior to calling the EAP. Please note that we will cover backdated sessions up to 14 days beyond the session date, as long as they have NOT been sent to or paid by insurance and the client has not paid for the session(s).
- 3) The EAP staff will serve as the Evaluator’s point of contact and any EAP staff member can provide assistance. In most cases, the client will contact the Evaluator directly to schedule each appointment. There are times, however, when the Evaluator will be instructed to call the client. The role of the EAP staff is to help direct each client to an appropriate Evaluator; however, if you receive a referral for a client that you are unable to assist for any reason, please notify the EAP staff immediately so that we may refer the client elsewhere.
- 4) The Evaluator will schedule a face-to-face, telephonic, or “virtual” (online session, also referred to as “telehealth” or “telecounseling”) initial session 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 timeframe (for example, needing an 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 this agreement. If the client does not wish to wait, he or she is welcome to call Mazzitti & Sullivan back and obtain a referral to another Evaluator. If the client requests an appointment beyond three working days, the Evaluator should proceed with scheduling and inform the EAP staff of the client’s preference and appointment information.
- 5) For “telehealth” appointments, we require that you utilize a HIPAA-compliant, secure system. Proof of the online platform’s security and/or HIPAA-compliance must be provided upon request.
- 6) The EAP sessions (initial as well as follow up appointments) should be approximately 50-60 minutes in length. If the client is required to complete additional paperwork for your own records, this paperwork should be completed by the client **prior** to the initial evaluation.
- 7) 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 staff should be notified immediately.**

- 8) The Evaluator will contact the EAP staff to confirm the date and time of the scheduled evaluation via email to [info@mseap.com](mailto:info@mseap.com) (you may use initials or the EAP Code for reference) or by calling our toll-free number, 1-800-543-5080. During non-business hours, you may leave messages with our confidential answering service with the client name or EAP Code and relevant appointment information.
- 9) Prior to the start of the first appointment with an EAP client, 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 staff. ***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 form also allows the client to communicate his or her satisfaction with the EAP up to the present point. 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. In this situation, the EAP **will** pay you for the session. Submit the Information and Consent form to the EAP with your completed Invoice and note “Refused to sign” on the signature line of the form.
- 10) At the initial counseling session, please offer the Notice of Privacy Practices (NPP) Summary to the client. Included in this packet is a copy of the Full Version of our NPP and may be provided to clients upon request. This NPP may also be obtained by contacting the EAP via phone or email.
- 11) After each counseling session (or within 14 days of the session date), the Evaluator will need to complete the **EAP Invoice** and submit it to Mazzitti & Sullivan EAP Services. Copies of our required EAP forms are included for your reference, and you will also receive blank copies with each EAP Referral Authorization form.
  - a) You **must** submit your request for reimbursement on the provided EAP Invoice. This form contains additional session summary information for our records. All fields are required. We are not an insurance company and are unable to accept HCFA-1500 forms.
  - b) You will need to choose an invoice or reference number for each client/date of service – this is your responsibility and will help you to track payments for each client/date of service. Please do **not** use any personally identifiable information or protected health information (PII or PHI) on the invoice.
  - c) The consent form **must** be received before the provider can be reimbursed for EAP sessions. If for some reason the client was unable to sign the EAP Consent form, you may send us the form signed by the client to consent to be treated, as issued by you/your agency. For telephonic/virtual sessions, if you are unable to obtain a physical signature, you may obtain a verbal consent from the client. In this case, please write “verbal consent” on the signature line, clearly print the client’s name where indicated, and sign as the Witness. If we do not receive this, we will call or email you to obtain it; you will have 30 days to send it to us. If it is not received within that time, we will return your invoice to you for resubmission.
  - d) The **EAP Invoice** is a fillable PDF and may be emailed (with the Consent, if it is the first session) to [info@mseap.com](mailto:info@mseap.com) within 14 days after the date of service. Please contact the

EAP staff (call 1-800-543-5080 or email [info@mseap.com](mailto:info@mseap.com)) if you have an invoice that is greater than 14 days old to request an exception. Please note that you must complete **all** fields on the invoice, including your address and phone, even if we have them on file, to ensure prompt payment.

- 12) EAP sessions issued to multiple family members may be used individually or with multiple clients in the same session. Regardless of the number of family members in the session, the 50-60 minute appointment is considered as one (1) session. Couples or families may use their sessions in any combination that is appropriate; however, family members who are not attending any sessions may not transfer sessions to another family member.
- 13) Upon completion of the EAP-authorized session(s):
  - a) The Evaluator may continue to see the client or refer elsewhere, as appropriate. We encourage clients to continue counseling if needed; however, payment would then be the client's responsibility (either via insurance or self-pay). The EAP is not a substitute or replacement for the client's insurance coverage.
  - b) 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.
    - 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.
    - 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.
- 14) The Evaluator will assist the client in contacting and arranging an appointment with the agency to which the client is referred.
- 15) 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.
- 16) The Evaluator must consult with the EAP staff if unusual circumstances or problems occur with the client and/or referral process.
- 17) Please do not discuss any details regarding reimbursement rates or payment timeframes with the client. Questions or concerns about these topics should be directed to the EAP staff.
- 18) 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, either in whole or in part. Mazzitti & Sullivan EAP Services does not reimburse for "no-show" or "late cancel" sessions. You may only bill the client for no-show/late cancellations if the client has signed an agreement to allow you to do so.

## ***Licensing and Liability***

Mazzitti & Sullivan EAP Services will allow any non-licensed clinicians to join its EAP network **as long as** the clinician is being **supervised by a licensed clinician** and that the EAP client is made aware of this condition. Current copies of license(s) must be made available to the EAP staff upon request.

**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 Evaluator. The 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), and \$3,000,000.00 aggregate, 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.

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).

*Continued next page*

## ***Reimbursement & Procedure***

Payment for EAP services rendered will be issued within 4-6 weeks from the date of receipt, provided all paperwork is appropriately submitted. The Evaluator must use the **EAP Invoice Form** to bill Mazzitti & Sullivan EAP Services for the session(s) performed (one invoice per client) within 14 days of the date of service (if you have an invoice outside of this timeframe, please call us for an exception). Please use the “fillable” PDF form to complete the required information, save the document, and then email to [info@mseap.com](mailto:info@mseap.com) for processing. You may download Adobe Acrobat Reader at no charge from <https://get.adobe.com/reader/> to view and fill in the PDF. The MS Word version of the EAP paperwork is available upon request.

Reimbursement will be provided via Direct Deposit (the enrollment form is included and must be returned with your EAP Provider paperwork). If at any time you need to change your banking or personal information, please notify us immediately. You may use the enrollment form to send us the updated information by checking the “Change” box at the top.

Payments will be issued from “Pyramid Healthcare” and you will receive an email notification when the payment is being requested, with the EAP Invoice number, the total amount, the EAP Client Code(s), date(s) of service, and your own invoice/reference number(s). The EAP Client Code appears in the top left of the EAP Referral Authorization form; please retain this number for your reference. One EAP Client Code may refer to multiple clients within a family. If you misplace this number, you may call the EAP at 1-800-543-5080 to obtain the client name(s). When you receive payment, there may be multiple EAP Invoice numbers attached to it; if you have any questions, please contact us.

Providers who are reimbursed more than \$600.00 per calendar year will receive a 1099 form for tax purposes. This will be mailed to the address listed on your W-9 form and linked to your Tax ID number (or SSN, if you do not have a Tax ID number). It is important to update this address with us prior to January 1<sup>st</sup> of each year if it has changed. We are not responsible for lost or misdirected mailings, though if you require a replacement 1099 we can request one for you.

# 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 and procedures (\$60/session)

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.

\_\_\_\_\_  
Evaluator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Administrative or Supervisory Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mazzitti & Sullivan EAP Services Representative

\_\_\_\_\_  
Date

*Please return via email to Mazzitti & Sullivan EAP Services along with the Counselor's license (if available) and liability coverage. Please 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 Mazzitti & Sullivan EAP with a signed copy of the Letter of Understanding, a copy of your state-issued license, 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) List age range you are comfortable counseling (for example "10 & up") \_\_\_\_\_

6) Do you have any specialties?

- |   |   |   |                                     |
|---|---|---|-------------------------------------|
| <input type="checkbox"/> Couples/Marital      | <input type="checkbox"/> Family counseling      | <input type="checkbox"/> Grief & Loss           | <input type="checkbox"/> Stress     |
| <input type="checkbox"/> Addictions (non D/A) | <input type="checkbox"/> Substance Abuse        | <input type="checkbox"/> Health issues          | <input type="checkbox"/> Trauma     |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Depression             | <input type="checkbox"/> Art therapy            | <input type="checkbox"/> EMDR       |
| <input type="checkbox"/> Parenting            | <input type="checkbox"/> Faith Based Counseling | <input type="checkbox"/> ADD/ADHD - coping      | <input type="checkbox"/> Asperger's |
| <input type="checkbox"/> Playtherapy          | <input type="checkbox"/> LGBTQ issues           | <input type="checkbox"/> ADD/ADHD Testing       | <input type="checkbox"/> Autism     |
| <input type="checkbox"/> Men's issues         | <input type="checkbox"/> Women's issues         | <input type="checkbox"/> Bilingual (list below) | <input type="checkbox"/> Anger      |
| <input type="checkbox"/> Abuse Victims        | <input type="checkbox"/> Geriatrics (over 65)   | <input type="checkbox"/> Career Counseling      | <input type="checkbox"/> Hypnosis   |
- Other (attach additional page if needed): \_\_\_\_\_
- 

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

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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  
(If Yes, please attach a copy of your certification. These evaluations are NOT covered under the EAP services.)

10) Other services you are willing to provide (\* = separate reimbursement rate):

- Online/Virtual Counseling  Telephonic Counseling  Trainings\*  On-Site Counseling\*
- Other: \_\_\_\_\_

## 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) Main office address: \_\_\_\_\_  
\_\_\_\_\_

3) Main telephone # of practice: \_\_\_\_\_

4) Main fax # of practice: \_\_\_\_\_

5) E-mail: \_\_\_\_\_

6) How do you prefer to receive referrals? (Fax or Email) \_\_\_\_\_

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 able to do telephonic or online counseling?

Telephonic:  No     Yes

Online:  No     Yes – What platform/software? \_\_\_\_\_

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

Name/Title \_\_\_\_\_

Phone \_\_\_\_\_ Extension \_\_\_\_\_ Email \_\_\_\_\_

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): \_\_\_\_\_

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

Main office number                       Individual office where client will be seen

12) Please list all insurances accepted by your practice (use separate sheet if necessary):  
\_\_\_\_\_  
\_\_\_\_\_

13) Hours available (generally):

Daytimes \_\_\_\_\_  Evenings \_\_\_\_\_  Weekends \_\_\_\_\_

Mazzitti & Sullivan EAP Services is a subsidiary of Pyramid Healthcare, Inc. You will receive reimbursement by direct deposit to the bank account of your choosing. An email address is required for payment notifications.

Please complete the information below and return using one of the methods below:

Email to: info@mseap.com

Mail to: 479 Port View Drive, Suite C30, Harrisburg, PA 17111

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## Vendor ACH / Direct Deposit Authorization Form

Pyramid Healthcare, Inc. and Subsidiaries, Office of Accounts Payable

**1. Please Check One:**

NEW Direct Deposit

CHANGE Direct Deposit

**2. Vendor / Payee Information:**

Name:

Address:

Contact Person's Name (if other than payee):

Telephone Number:

Email Address:

**3. Financial Institution Information:**

Bank Name:

Bank Address:

Name on Bank Account:

Bank Account Number:

Nine-Digit Bank Routing / Transit Number (ABA):

Type of Account:

Checking

Savings

**4. Approvals / Authorizations** – I certify that the information provided on this form is correct, and I hereby authorize Pyramid Healthcare, Inc. and its Subsidiaries to electronically deposit payments to the bank account designated above. It is my responsibility to notify Pyramid Healthcare, Inc. immediately if I believe there is a discrepancy between the amount deposited to my bank account and the amount of the invoice(s) paid. I understand that I must notify Pyramid Healthcare, Inc. in writing immediately of any changes in status or banking information. I understand that this authorization will remain in full force and effect until Pyramid Healthcare, Inc. has received written notification requesting a change or cancellation and has had reasonable opportunity to act on it, which should take no longer than seven (7) to ten (10) business days.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mazzitti & Sullivan EAP Services – Notice of Privacy Practices**  
*(Full version – please provide to clients upon request)*

**Privacy is a very important concern for all those who contact our EAP. If you have any questions, please contact the EAP staff.**

**Contents of this Notice**

- A. Introduction to our clients**
- B. What we mean by your medical information**
- C. Privacy and the laws**
- D. How your protected health information can be used and shared**
  - i. Uses and disclosures with your consent**
    - 1. The basic uses and disclosures – for treatment, payment, and health care operations (TPO)**
    - 2. Other uses and disclosures in health care**
  - ii. Uses and disclosures *requiring* your Authorization**
  - iii. Uses and disclosures *NOT requiring* your Consent or Authorization**
  - iv. Uses and disclosures requiring you to have an opportunity to object**
  - v. An accounting of disclosures we have made**
- E. If you have questions or problems**

## A. Introduction to our clients

This Notice will tell you about how we handle your information. 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions or want to know more about anything in this Notice, please contact the Director of EAP Operations.

## B. What we mean by your medical information

Each time we are contacted by you or a provider, information is collected about your mental health. It may be information about your health conditions, the treatment or services you received, or about payment for health care. The information we collect from you is called **Protected Health Information (PHI)**. This information goes on your **medical or health care records**. 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

We use this information for many purposes. For example:

- 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 measuring the results of our work

Although your health record is the physical property of the health care practitioner or facility that collected it, the information belongs to you. If you would like a copy of your records it can be provided upon request. If you find anything in your records that you think is incorrect, or missing, you can ask for it to be amended. In unique cases, some information will be inaccessible to the client or unable to be changed.

## C. Privacy and the laws

The HIPAA law requires us to keep your PHI private and to provide you with a Notice of our legal duties and our Privacy Practices (**Notice of Privacy Practices** or **NPP**). We will obey the rules of this Notice as long as it is in effect, but your PHI is subject to any changes in the NPP. If we change the NPP, we will post the new Notice in our office or on our website at [www.mseap.com](http://www.mseap.com). If a copy is required at any time, please contact the Director of EAP operations.

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

By Law, when your information is read by anyone, that is called, “**use**.” If the information is shared with others, that is called “**disclosure**.” Only in special circumstances do we disclose your PHI to outside parties. In these circumstances we are careful to only disclose the **minimum necessary** information needed. You have a legal right to know about your PHI and how it is used and disclosed. Mainly, we use and disclose PHI for routine purposes explained below. We must tell you about non routine uses and have a written authorization unless the law states otherwise.

### i. 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. We intend to use your PHI here and/or share with other people and organizations to provide **treatment** to you, arrange for **payment** for services provided, and/or 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.

#### 1. 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, use, and share the information to care for you properly. Therefore, you must sign the Consent form before your counselor begins to treat you, because if you do not consent he/she cannot treat you.

When you see your counselor, several people in that office may collect information about you and it will be recorded into your health care records. Generally, we may use or disclose your PHI for three purposes: treatment, providing payment, and other 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 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

to create a Treatment Plan. If you receive treatment in the future from other professionals accessed through Mazzitti & Sullivan EAP Services, we can disclose your PHI to them.

#### *For payment*

Your counselor may use this information to bill you, your insurance, Mazzitti & Sullivan EAP Services, or others to be compensated. We or your counselor may contact your insurance company to check on exactly what your insurance covers. They may request information regarding your diagnoses, what treatments you have received, and your treatment process. They may require information on your past and future appointments.

#### *For health care operations*

Certain health care operations may require us to disclose your PHI. For example, we may use your PHI to see where we can make improvements in our service, or supply information to government health agencies so they can study disorders, treatments, and develop services. If we do, your name and other identifying information will be removed from what we send.

## **2. 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 email you only at specific locations, it can 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 from 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. For example, Business Associates may include a copy service that 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.

### **ii. Uses and disclosures *requiring* your Authorization**

If we want to use your information for any purposes besides the TPO, or those described above, we need your permission on an **Authorization Form**. If you do authorize us to use or disclose your PHI, you can revoke that permission, in writing, at any time. However, we cannot take back any previously disclosed information.

### **iii. 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 are mandated reporters; any reported child abuse will be disclosed to the appropriate responders
- If you are involved in a 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 informing you, consulting your lawyer, or trying to get a court order to protect the information they requested
- We have to release some information to the government agencies that monitor 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 others we can disclose some of your PHI to persons who can prevent the danger.

### **iv. 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 about your treatments and conditions with those involved in your care and those whom you choose. You can communicate your preferences and we shall honor your wishes as long as it is not against the law.

If it is an emergency where we cannot confirm consent, we can share information if we believe that it will improve your current situation. If we do share information in an emergency, we will notify you as soon as we can. If you don't approve, we will cease disclosure, as long as it is not against the law.

**v. An accounting of disclosures we have made**

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 of these disclosures upon request.

**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 Director of EAP Operations, 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 Director of EAP Operations. 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.

**Director of EAP Operations.: Cheryl Raudenbush, 1-800-543-5080; email: [CRaudenbush@mseap.com](mailto:CRaudenbush@mseap.com)**