



Client Information Form

Client Name: _____

Case # _____ [Magellan will supply the number]

First Appointment Date: _____

Address:		City:
State:	ZIP:	Do we have permission to contact you at the above address? <input type="checkbox"/> Yes <input type="checkbox"/> No

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth: _____
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Work Telephone Number:		May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Telephone Number:		May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Number:		May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Employer or Organization through which you are accessing EAP:				
Employee's Name:		Employee's Job Title:		Length of Service:

Your Status:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee Spouse	<input type="checkbox"/> Employee Child	<input type="checkbox"/> Other
	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree Spouse	<input type="checkbox"/> Retiree Child	

Do you have health coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(if Yes) Name of organization(s) through which you are covered:
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How did you access the EAP?	<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Family Initiated	<input type="checkbox"/> Medical Department Referral/Human Resources	<input type="checkbox"/> Primary Care Physician Referral
	<input type="checkbox"/> Supervisor Recommendation (Informal)	<input type="checkbox"/> Supervisor Referral (Formal)	<input type="checkbox"/> Mandatory Supervisor Referral	<input type="checkbox"/> Other: _____

Were you referred for a work performance problem? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please indicate the type:	<input type="checkbox"/> Absenteeism / Tardiness	<input type="checkbox"/> Safety / Security	<input type="checkbox"/> Work Relationships	<input type="checkbox"/> Quantity / Quality of Work	<input type="checkbox"/> Positive Alcohol / Drug Test	<input type="checkbox"/> Other

What concerns brought you to the EAP?
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What do you want to see happen as a result of coming here?

What have you tried on your own to solve your concerns?
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Healthy Habit Information (please base your answers on the past month):	
° Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
° Have you been dieting to lose weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
° Have you smoked cigarettes on a daily basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

How often in the past month did you drink alcohol?				
A) I do not drink at all	B) About once a month	C) 2 to 3 times a month	D) 2 to 3 times a week	E) Once a day or more

OPTIONAL:	Education (Years completed or degree earned):	Legal Issues <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Service: <input type="checkbox"/> Yes <input type="checkbox"/> No
	_____			Branch(es): <input type="checkbox"/> Present <input type="checkbox"/> Past

Client Signature _____

Date _____

MAGELLAN BEHAVIORAL HEALTH MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services. If asked, Magellan will act on the member's behalf as an advocate.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature

Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature

Date



Mandatory Referral STATEMENT OF UNDERSTANDING

You have been referred to the Employee Assistance Program (“EAP”) which is provided through a Magellan Behavioral Health* company (“Magellan”). EAP services are available to employees and their family members on a prepaid, contractual basis. The EAP counselor will work with you to clarify the problem, identify choices, and develop an action plan. Magellan customer service associates and EAP consultants are available to respond to your call 24 hours a day, 365 days a year.

MANDATORY REFERRAL

You have been referred to the EAP because _____. Magellan will make an assessment of your problems and provide you brief counseling and/or a professional referral, as appropriate. In order to assist your employer in determining your continuing employment status, you will be asked to sign an authorization permitting certain communications between the EAP and your employer and/or the treatment provider to which the EAP refers you. Under your employer's policy, your job is at risk if you do not cooperate with the EAP (including signing the authorization) and follow the EAP's treatment recommendations.

FEES

EAP services are provided without cost to you. Your employer has already paid for this service. **It is your responsibility to pay for services provided by any resources outside the EAP.** (Your benefit plan may defray some of the cost of services provided by outside resources.)

CONFIDENTIALITY

The EAP will maintain confidential records of your contact with the EAP and the services provided to you in order to provide continuity and coordination of your care.

Information about your use of the EAP will not be revealed to anyone outside the EAP *except* in the following circumstances:

(1) you consent in writing; (2) life or safety is seriously threatened; (3) disclosure is required by law. Depending on the privacy policy of the employer, the employer’s privacy official might have access to information in connection with the employer’s obligations in the Privacy Rule under HIPAA (the Health Insurance Portability and Accountability Act). Check the employer’s privacy policy to see if the privacy official or anyone else will have access to information.

Under your employer’s policy, Magellan is expected to confidentially advise your employer whether you are cooperating with the EAP and following the EAP’s treatment recommendations. To permit Magellan to do so, you will need to sign an authorization to disclose that information. However, you may use EAP services even if you do not consent to the disclosure. Magellan may confirm information previously given to your employer per your signed authorization in any legal proceeding between you and your employer that arises from your failure to follow EAP treatment recommendations.

Also, your EAP counselor will disclose information and records to Magellan as needed for coordination of EAP services, quality assurance, or payment. Professional auditors not employed by your employer may also examine your file at Magellan's quality assurance office to evaluate the EAP.

I, (print name) _____, understand this form, including the confidentiality of the EAP and the limitations to confidentiality, and accept it as the terms of my participation in the program. As an EAP consumer, I also understand that I may request written information describing Magellan's confidentiality policy and/or my EAP clinician’s confidentiality policy.

Signature

Witness

Parent, guardian, or legal representative (when required) Date

Counselor Signature: _____ Initial if a copy was given to client.

*Services in California are delivered by Human Affairs International of California or Magellan Health Services of California—Employer Services.