MAGELLAN HEALTH SERVICES®
Getting Better All the Time™

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?** ☐ **Yes** ☐ **No**

Gender: ☐ Female ☐ Male		**Date of Birth:**			
Work Telephone Number:		May we call you at this number?	☐ Yes ☐ No	May we leave a message?	☐ Yes ☐ No
Home Telephone Number:		May we call you at this number?	☐ Yes ☐ No	May we leave a message?	☐ Yes ☐ No
Emergency Contact Number		May we call you at this number?	☐ Yes ☐ No	May we leave a message?	☐ Yes ☐ No

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

Your Status:	☐ Employee	☐ Employee Spouse	☐ Employee Child	☐ Other
	☐ Retiree	☐ Retiree Spouse	☐ Retiree Child	

Do you have health coverage?	☐ **Yes** ☐ **No**	(if Yes) **Name of organization(s) through which you are covered:**

How did you access the EAP?	☐ Self-Referral	☐ Family Initiated	☐ Medical Department Referral/Human Resources	☐ Primary Care Physician Referral
	☐ Supervisor Recommendation (Informal)	☐ Supervisor Referral (Formal)	☐ Mandatory Supervisor Referral	☐ Other: _____

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

What concerns brought you to the EAP?

What do you want to see happen as a result of coming here?

What have you tried on your own to solve your concerns?

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?** ☐ **Yes** ☐ **No**
- **Have you been dieting to lose weight?** ☐ **Yes** ☐ **No** ☐ **NA**
- **Have you smoked cigarettes on a daily basis?** ☐ **Yes** ☐ **No**

How often in the past month did you drink alcohol?

◯ I do not drink at all	◯ About once a month	◯ 2 to 3 times a month	◯ 2 to 3 times a week	◯ Once a day or more

OPTIONAL:	Education (Years completed or degree earned): _____	Legal Issues ☐ **Yes** ☐ **No**	Financial problems: ☐ **Yes** ☐ **No**	Military Service: Branch(es): ☐ **Yes** ☐ **No** ☐ **Present** ☐ **Past**

Client Signature _____ **Date** _____

 Rev. 11/08

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

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STATEMENT OF UNDERSTANDING

You have chosen to receive employee assistance program ("EAP") services which are provided through a Magellan Behavioral Health* company ("Magellan"). EAP services may include assessment and referral or brief counseling. 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.

FEES

These services are provided at no direct cost to employees and family members. The employee's company pays for the services. However, if you need longer-term counseling or a specialized service, Magellan will assist in locating a resource or service in the community. **It is your responsibility to pay for services provided by any resources outside the EAP.** (Your benefit plan may cover some of the cost. **Check with your benefits representative before services are 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.

No one will reveal information concerning your use of the EAP to anyone outside the program except as follows: (1) you consent in writing; (2) life or safety is seriously threatened; (3) disclosure is required by law; or (4) your counselor refers you to benefits-covered treatment and the claims payor requires information. In addition, your counselor will disclose information and records to Magellan as needed for coordination of EAP services, quality assurance, or payment. Professional auditors (not employed by the employee's company) may also examine your file to evaluate the services. 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.

IF YOU HAVE BEEN REFERRED TO THE PROGRAM DUE TO A WORK PERFORMANCE PROBLEM:

Under your employer's policy,

1) Magellan is expected to confidentially advise the referral source whether you are participating in the EAP and cooperating with the EAP plan. To permit Magellan to do so, you will need to sign an authorization permitting disclosure of that information. However, you may use EAP services even if you do not sign an authorization. Your personal problems will not be discussed with the referral source, unless you request, in writing, that this be done.

2) Participation is voluntary--whether or not you decide to use the EAP services, your decision will not affect your employment security or advancement opportunities.

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 the EAP counselor'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.