The Counseling Team International
41750 Rancho Las Palmas Dr. Ste #O-2
Rancho Mirage, CA 92270
Ph: (800) 651-1021 Fax: (760) 636-0437
Email: deaeapbilling@thecounselingteam.com

ADMISSION FORM

Case #:_____ **Therapist Name:** Donna C Fortney, LPC

Intake Date: _____

Client Name: _____ **Client Gender: M** ☐ **F** ☐ **DOB:** _____

Address:_____ **Relationship: if not employee** _____

_____

Contact Phone: _____

Employee Name: _____

Current Address (If different) _____

_____

Phone: _____ DOB: _____

Division: _____

Employment City: _____

Employee Job Classification:

☐ Agent/Pilot
☐ Technical/Clerical
☐ Professional/Admin.
☐ Diversion Investigator
☐ Chemist
☐ Intelligence Research Spec.

Type of Problem ***(check one only)***	✓	***Symptom Description***
Emotional		
Relationship/Family		
Occupational		
Substance Abuse		
Phase of Life Problems		

PROBLEM STATEMENT:

TREATMENT PLAN/GOALS:

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STATEMENT OF UNDERSTANDING AND CONSENT

CASE NUMBER: _____

The Employee Assistance Program (EAP) is a confidential and voluntary program established under 5 U.S.C. §§ 7901 and 7904 that provides assessment, short –term counseling and referral services for a wide range of personal and job-related concerns. The EAP maintains records to document assessment, intervention, and follow-up activities. The Privacy Act, 5 U.S.C. § 552a, protects the privacy and limits the disclosure of these records. If this counseling is not being conducted in person, the servicing Clinician must review this Statement of Client Understanding contents with each EAP client and they must affirm that they understand and agree to terms. Such approval must be noted in the client's EAP record and whenever possible, a copy of the signed Statement of Client Understanding placed in their EAP file.

The EAP *may* disclose specific relevant information in certain limited circumstances, including the following:

- If you consent in writing.
- To appropriate State or local authorities to report, where required under State law, incidents of suspected child, elder or domestic abuse or neglect.
- To any person or entity to the extent necessary to prevent an imminent crime which directly threatens loss of life or serious bodily injury.
- To contractors that provide counseling and other services to the extent that it is appropriate, relevant and necessary to enable the contractor to perform his or her counseling, treatment, rehabilitation and evaluation responsibilities.
- To any person who is responsible for the care of an EAP client when the EAP client to whom the records pertain is mentally incompetent or under legal disability.
- To any person or entity to the extent necessary to meet a bona fide medical emergency.
- To qualified personnel for research, audit, or program evaluation. (Such disclosure, if made, will not identify you by name).
- If the disclosure is required by a valid court order.
- To defend the EAP or its employees in litigation.
- When a direct supervisor requires confirmation that you have made or kept EAP appointments as the result of a formal supervisory referral and/or a non-leave absence has been used for an EAP appointment.

Disclosures of records relating to clients who contact the EAP for alcohol or drug abuse problems are further limited by federal law, 42 U.S.C. § 290dd-2.

I understand that before the initiation of in-person clinical services, as an EAP client, I am required to review and sign this Statement of Client Understanding certifying that I understand and agree: to my responsibility in the therapeutic process; that the initial assessment is free of charge; that if short-term counseling is determined to be clinically appropriate, the EAP counselor or local affiliate will also provide this service at no cost to me for up to a maximum of six sessions; that the Drug Enforcement Administration EAP, its EAP Contractors and its customer organizations are not responsible for the treatment costs and/or services for which I may be referred beyond the EAP counselor or local affiliate counselor; and that it is my sole responsibility to pay for all such non-EAP services including all charges not covered by insurance plans.
I have read the above statements, and I understand and agree to them.

Client Name _____
(Please Print)

Client Signature _____ Date _____

EAP Counselor Donna C Fortney, LPC Date_____

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CLIENT SATISFACTION SURVEY AUTHORIZATION

Upon completion of counseling sessions with your clinician from the DEA Employee Assistance Program (EAP), we would like feedback regarding your satisfaction with the services you have received. With your permission, the DEA EAP Contractor will contact you by telephone to conduct a five minute survey.

The information collected will be used to improve the quality of our services to DEA employees and their family members.

Your responses will be confidential and never be linked to you in any way.

If you are willing to participate in the survey, please indicate this by filling out the information requested below and return it to your EAP Clinician immediately. If you do not wish to participate in the survey, please write your name on the first line and check the box at the bottom of the page.

The choice is completely yours. Thank you for your assistance.

Clinician's Name: Donna C Fortney, LPC

Your Name: _____

Telephone number to call: _____

Best time to reach you: _____

Signature: _____

Date: _____

☐ I Do Not Wish To Be Contacted

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CLINICAL SERVICE RECEIPT

Submit one form for each session

Case Number: _____ **Therapist Name:** Donna C Fortney, LPC

Date of Session:_____ **Session #:** _____ **(1-6)** ***Check if this is the Final Session:*** ☐

Session Duration:_____**(Hours)** **EMDR Session:** ☐

I ACKNOWLEDGE THE SERVICES WERE PROVIDED:

_____ _____

Print Name of Employee or Family Member **Signature of client or consenting adult (client under 18)**

Narrative/ Description of Session:

_____
_____
_____
_____

DISCHARGE -DISPOSITION SUMMARY:

If this is the Final Session, please provide a brief summary of any improvements and follow-up recommendations:

_____
_____
_____
_____
_____
_____
_____

Check one: Improved ☐ Not Improved ☐

If recommendation includes additional sessions, please submit Form # 11: Authorization to extend EAP Services.