CLINICAL COUNSELING
&Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

EAP Treatment Waiver Form

Patient Name: _____

Name of Provider: _____

If the individual or individual's family member(s) need long term counseling, mental health treatment, or therapy, Clinical Counseling and Consulting Services, PLLC (CCCS) will refer to other professionals or services covered by the individual's insurance within the individual's community. However, CCCS understands, that at times, other resources may not be available or the individual or family member(s) may prefer to continue service with CCCS.

To protect individuals from a potential conflict of interest, we require this "Treatment Waiver Form" is provided, explained and signed by the individual requesting services beyond EAP.

The EAP industry does not encourage self-referrals as a counselor could recommend additional therapy as a way of generating business for themselves or their practice. To ensure that the individual has provider choice CCCS will offer three additional referrals other than themselves or any other person, or organization where they may have financial interest, before asking the individual to consent. Providers are listed below.

Referral Name: _____ Phone Number: _____

Referral Name: _____ Phone Number: _____

Referral Name: _____ Phone Number: _____

I, _____ am requesting to continue counseling beyond my EAP benefit with_____. I understand that I will be responsible to determine if a provider and/or a service is covered by my health insurance benefit plan. I understand that I will be responsible for all services rendered beyond the scope of my EAP benefit.

_____ _____
Patient Signature/Date CCCS EAP Counselor Signature/Date

_____ _____
Patient Name (Print)/Date CCCS EAP Counselor Name (Print)/Date