Description of Services

1. What is Employee Assistance of the Pacific and what are EAP (or PAP) services?

Employee Assistance of the Pacific, LLC is Hawaii's largest provider of Employee Assistance Program (EAP) and Physician Assistance Program (PAP) services. EAP and PAP services are a short-term counseling and referral service, the purpose of which is to assist employees with resolving personal problems that may be interfering with work or disrupting their lives. Employers provide these services at no charge to employees or physicians.

2. What happens if I miss a session?

You are asked to call at least 24 hours in advance to cancel your appointment. Late cancellations or no-shows may be subtracted from your total annual benefit.

3. What about confidentiality?

Confidentiality is extremely important. Brief records are kept only to assist in evaluation and treatment and are not made a part of your personnel or medical files. Information obtained during our contacts will not be revealed to any person or agency outside EAP without your written consent.

If your employer has formally referred you to EAP, your counselor will inform you as to the limited information that we will need to provide your employer per your signed release. Only with your signature may your counselor reveal any limited confidential information with your employer.

EAP counselors may disclose information and records to the EAP as needed for coordination of EAP services, quality assurance, and/or payment. may be required by law to disclose information to appropriate authorities under certain conditions. They include:

1) Threat of bodily harm or death to another person or yourself;
2) Abuse or neglect of a child or elder;
3) A legitimate subpoena issued by a court of law for information specifically described in the subpoena; and
4) As required by federal or state laws.

If you have provided an email address and consent, you understand that you may receive electronic information including referral, resource, and survey material from the EAP/PAP. By providing this consent you understand that this emailed information may not be secure, and you may retract this consent at any time by calling the EAP/PAP.

Acknowledgment:

____ I acknowledge that the information above has been reviewed by me and/or my counselor.
____ I have reviewed the attached Employee Assistance of the Pacific's Notice of Privacy Practices.

I understand this form, including the confidentiality in the EAP/PAP and the limitations to confidentiality, and accept it as the terms of my participation in the program. I understand that my participation is voluntary and that I can discuss any questions with my counselor during my first visit.

Client Signature: ____ Date: ____________
(If Client is under the age of 18 Parent or Authorized Representative Signature also required)

Authorized Representative Signature: ________________________________ Date: ____________
Relationship to client: ______________________________

Counselor Signature: ____ Date: ____________

Client Intake Form

Client's Name: ________________________________

Name you prefer to be called: ____________________

Home Address: _______________________________

City: _________________ Zip Code: _____________

Phone Numbers:	Okay to call	Okay to leave message
H) ____________________	☐ Yes	☐ Yes
W) ___________________	☐ Yes	☐ Yes
Cell: __________________	☐ Yes	☐ Yes

Email:____________________________________

May we email you? ☐ Yes ☐ No

Birth Date: __________________ Age: __________

Gender: ☐ Female ☐ Male ☐ Other

Last 4 digits of Social Security Number:___________

Briefly describe your reason for contacting us:

____

____

How long has this been a problem for you?

____

What other ways have you tried to handle this problem?

____

What would you like to accomplish by coming here?

____

____

Overall, how serious is this problem for you?

Not Very Serious ... Very Serious

1 2 3 4 5

Education: *Please check the highest level of education you have completed*

☐ Elementary School ☐ High School
☐ 2-Year College Degree ☐ 4-Year College Degree
☐ Postgraduate College Degree
☐ Other Education: ___________________________

Ethnic Identity: ______________________________________

Employer:____

Job Title: _______________________________________

Dept. Name: ____________________________________

Are you a veteran of the U.S. Armed Forces? ☐ Yes ☐ No

What is your current employment status? *(please check)*

☐ Full-Time ☐ Suspended
☐ Part-Time ☐ On leave, disabled
☐ Other, Specify: __________________________

Altogether, how long have you been employed by your current company?

____

Job level *(please check)*

☐ Management ☐ Trade/Technical
☐ Professional ☐ Support

Are you a Union Member?

☐ Yes Name of Union: ________________________
☐ No

If you are not the employee with EAP benefit:

Employee name___________________________________

Employee Company_______________________________

Relationship to you_______________________________

Type of medical insurance?

☐ HMSA ☐ Kaiser ☐ Other *(please specify):*
☐ UHA ___________________________

Education: *Please check the highest level of education you have completed*

☐ Elementary School ☐ High School
☐ 2-Year College Degree ☐ 4-Year College Degree
☐ Postgraduate College Degree
☐ Other Education: ___________________________

How did you learn about the Employee Assistance Program? (check all that apply)

☐ Home Mailing ☐ Doctor
☐ Posters/Flyers/Pamphlets ☐ HR/Personnel
☐ Seminar/Training ☐ Manager
☐ Family Member ☐ Union
☐ Other Employee ☐ Other

Who is primarily responsible for you coming to the EAP? *(In other words, who got you to come in?)*

☐ Myself ☐ Other Employee
☐ Supervisor/Management ☐ Human Resources
☐ Family Member *(please specify)*:______________________
☐ Other *(please specify)*:_____________________________

Do you have any of the following problems?
(Please check all that apply)

- ☐ Sleeping too little or too much
- ☐ Chronic tiredness or low energy level
- ☐ Feelings of inadequacy or loss of self-esteem
- ☐ Decreased productivity or effectiveness at school/work/home
- ☐ Decreased attention, concentration or ability to think clearly
- ☐ Withdrawing from friends
- ☐ Loss of interest or enjoyment in pleasurable activities
- ☐ Loss of interest in sexual activities
- ☐ Less active or talkative than usual
- ☐ Restless or anxious
- ☐ Pessimistic attitude toward the future, brooding over past events or self-pity
- ☐ Tearfulness or crying
- ☐ Recurrent thoughts of death or suicide
- ☐ Other *(please specify):* ____________________

Have you ever seriously contemplated or attempted suicide at any time in the past? ☐ Yes ☐ No

If yes, please explain:

____

____

____

What counseling or treatment have you had?
(please check all that apply)

- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Social Worker
- ☐ Self-Help Group
- ☐ Church Counselor
- ☐ Any other Counselor or Program (please specify): ______________________________

Marital Status:

☐ Single ☐ Separated
☐ Married ☐ Divorced/Single
☐ Cohabitating (living with partner)

If married/cohabitating:

How long have you been with your current partner?
____

Partner's Name: ________________________________

Age: ______ Occupation: __________________________

Employer: _____________________________________

Children:

Name	Age	Sex	Living with you?	Married?

Others living with you:

Name	Age	Sex	Relationship

Religious Affiliation or other Spiritual activities:

____

List Medications: (Prescription and Over the Counter)

	Reasons Taken	Dose/Frequency

Below are a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at EAP during the past 30 days. Please read each item carefully and answer as accurately as you can. Remember that your answers will not be shared with your employer.

1. For the period of the past 30 days, please total the number of hours your personal concern caused you to miss work. Include complete eight-hour days and partial days when you came in late or left early.	NUMBER OF HOURS				
INSTRUCTIONS FOR ITEMS 2 - 5 The following statements reflect what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1-5 response key to the right:	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEUTRAL	SOMEWHAT AGREE	STRONGLY AGREE
2. My personal problems kept me from concentrating on my work.	1	2	3	4	5
3. I am often eager to get to the work site to start the day.	1	2	3	4	5
4. So far, my life seems to be going very well.	1	2	3	4	5
5. I dread going into work.	1	2	3	4	5

Employee Assistance of the Pacific (EAP)

HIPAA Notice of Privacy Practices

1221 Kapiolani Blvd, Suite 730
Honolulu, HI 96814

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS EMPLOYEE ASSISTANCE OF THE PACIFIC'S (EAP'S) LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law we are required to ensure that your PHI is kept private. The PHI constitutes information created or noted by EAP that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. The EAP is required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how EAP would use and/or disclose your PHI. Use of PHI means when EAP would share, apply, utilize, examine, or analyze information; PHI is disclosed when EAP releases, transfers, gives, or otherwise reveals it to a third party outside of EAP. With some exceptions, EAP may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, EAP is always legally required to follow the privacy practices described in this Notice.

Please note that EAP reserves the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI already on file with EAP. Before EAP makes any important changes to policies, we will immediately change this Notice and post a new copy of it in the office and on the website. You may also request a copy of this Notice from us, or you can view a copy of it in our office.

III. HOW EAP WILL USE AND DISCLOSE YOUR PHI.

EAP will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of EAP uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

EAP may use and disclose your PHI without your consent for the following reasons:

1. For treatment. EAP may disclose your PHI to physicians, psychiatrists, psychologists, social workers and other health care professionals in an emergency situation.
2. For health care operations. EAP may disclose your PHI within our organization to facilitate the efficient and quality measures of our EAP to review the quality of the overall services that you have received or to evaluate the performance of the employee assistance professionals who provided you with these services. AGENCY may also provide your PHI to EAP attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable standards and or laws.
3. To obtain payment for treatment. EAP may use and disclose your PHI to bill and collect payment for the EAP services provided or a business associates, such as billing companies, claims processing companies, and others that process health care claims for EAP.

B. Certain Other Uses and Disclosures of your PHI Do Not Require Your Consent.

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm, PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Child Abuse and Neglect Reporting law if there is a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Elder/Dependent Adult Abuse Reporting law if there is a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. If disclosure is compelled or permitted by the fact that you report the commission of or contemplation of a commission of a crime.
11. For public health activities.
12. For quality review health oversight activities.
13. For specific government functions which impact national security, or veterans or military personnel.
14. For research purposes which may result in improved practices.
15. For Workers' Compensation compliance purposes.
16. If an arbitrator or arbitration panel compels disclosure.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, such as HIPAA compliance.
18. If disclosure is allowed by law for purposes of Public Safety under Department Of Transportation regulations.
19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

Disclosures to family, friends, or others. Your PHI may be provided to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in Sections IIIA, IIIB, and IIIC above, your written authorization will be obtained before using or disclosing any PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we haven't taken any action subsequent to the original authorization) of your PHI.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI.

You have the right to see your PHI, or to get copies of it; however, you must request it in writing. If EAP does not have your PHI, but knows who does, we will advise you how you can get it. You will receive a response from EAP within 30 days of our receipt of your written request. Under certain circumstances your request may be denied. If that is the case, EAP will give you, in writing, the reasons for the denial. Your right to a denial review will be explained as well. Copies of your PHI will not exceed $0.25 per page. With your approval you may be provided a summary or explanation of the PHI, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI.

You have the right to ask that EAP limit the use and disclosure of your PHI. While EAP will consider your request, we are not legally bound to agree. If EAP does agree to your request, we will put those limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that EAP is legally required or permitted to make.

C. The Right to Choose How We Send Your PHI to You.

It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method. EAP is obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures Made by EAP.

You are entitled to a list of disclosures of your PHI that EAP makes. The list will not include uses or disclosures to which you have already signed a consent/authorization for; uses or disclosures that are used for treatment, payment, or health care operations; or information sent directly to you or to your family. The list will also not include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 14th, 2003. Your request for an accounting of disclosures will be responded to within 60 days of receiving your request. The list will include disclosures made in the previous six years, beginning as of April 14th, 2003, unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed and the reason for the disclosure. This list is provided to you at no cost, unless you make more than one request in the same year, in which case charges based on a set fee for each additional request will apply.

E. The Right to Amend Your PHI.

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that corrections be made to the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. Your request may be denied in writing, if it is found that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of EAP records, or (d) original source is other than EAP. A denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If your request is approved, EAP will make the change(s) to your PHI, inform you that the changes have been made, and advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email

You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If, in your opinion your privacy rights have been violated, or if you object to a decision made about access to your PHI, you are entitled to file a complaint with the person listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about AGENCY privacy practices, no retaliatory action will be taken against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about EAP privacy practices, please contact David Mitchell, General Partner, Employee Assistance of the Pacific LLC, 1-808-597-8222

VII. TELEHEALTH SERVICES

If you choose to use Telehealth services (e.g. over the phone or via a video connection) you do so with several understandings in place, including: (a) These services are not for emergencies. (b) These services are not appropriate for high-risk individuals (e.g. risk of suicide or harm, drug and alcohol issues) or for children. You should seek emergency help or follow-up care when in a high risk situation or when recommended by your Provider. (c) You are providing consent for this service delivery model understanding that we cannot control your confidentiality to the same degree as face-to-face, in that we cannot control who is overhearing your phone or video conversations and we cannot control who has access to your phone or computer. (d) You understand that delays in evaluation or provision of services may occur due to failure of electronic equipment. (e) You understand that your Provider, in his or her sole discretion and professional judgment, may determine that telehealth services are not appropriate for some or all of your needs and, accordingly, may elect not to provide telehealth services to you.

VIII. EFFECTIVE DATE OF THIS NOTICE: March 18, 2020