Data Intake Sheet

Client Information
(Person presenting for service)

Client Name: ____ D.O.B.: ___________________

Home #: ___________________ Cell #: ___________________ Work #: ___________________

Safe Contact Number: (Check One)

Home:____ Work:____ Cell: ____ No Preference:____ Gender:___________ Marital Status:_______

Home Address: ____________________________ City: __________ State: _____ Zip: __________

Emergency Contact

Name/Relationship: _______________________ Emergency Contact Phone #: ________________

How did you find out about EAP?____

Person whose organization provides TEAM Corporation services

Union Member/ Policy Holder: ____

Union/Employer: ____

Local Number: ____

Reason for Visit

Please briefly describe your reason for today's visit:

Please turn the form over and read and sign the Statement of Understanding.

1970 Oakcrest Ave. Suite 200 Roseville, MN 55113
2002 London Rd. Suite 95 Duluth, MN 55812
10761 Virginia Plaza Suite 103 Papillion, NE 68128
N25W23055 Paul Rd. #3 Pewaukee, WI 53072
www.team-mn.com | 651.642.0182 800.634.7710

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STATEMENT OF UNDERSTANDING

Explanation of Services

TEAM (Total Employee Assistance Management) Corporation is a sponsored work place Employee Assistance Program and Patient Advocacy Program that provides services to members/employees and their dependents. Evaluation of life problems, short-term counseling, referrals, care coordination, medical advocacy and consultation are offered at no cost as part of your health benefits. Provision of specific TEAM services are determined by your organizations health plan.

It is important to note that TEAM does not clinically diagnosis conditions but will assist you with establishing a care provider to establish a diagnosis if needed.

Up to 6 counseling sessions are provided if working directly with one of TEAM's clinical staff via telehealth or in person. If you are located outside of a thirty mile radius of one of our locations and would like in person services, TEAM will establish an agreement with a community provider for three individual counseling sessions at no cost to you.

Referrals

It is up to the discretion of our trained TEAM professionals to determine if a presenting concern is appropriate to address or if a referral is necessary. TEAM Corporation will provide appropriate resources and referrals. Clients will be responsible for contacting their health plan to learn about any applicable cost. These referrals are suggestions; the decision to use or not to use these resources is at your discretion.

Limits of Confidentiality

All contact with TEAM Corporation is strictly confidential within the limits of the law. As mandated reporters, there are certain circumstances in which we are required to report information. Exclusions to confidentiality include:

- Child abuse or neglect
- Abuse or neglect of a vulnerable adult
- Specific threats of harm to individual(s)
- Specific threats of harm to self
- Sexual misconduct or abuse by a former counselor/therapist
- Drug use by a pregnant woman

TEAM Corporation may also be obligated to comply if a court order demands that we release information.

Employers/unions will not be informed that you have utilized TEAM services, with the exception of being formally referred to TEAM by your employer/union due to a work place issue. In this event, a TEAM staff will request that Release of Information forms be signed and will discuss with you the nature of the information that will be shared with your employer/union.

Federal Guidelines on Confidentiality:

Under the Health Insurance Portability and Accountability Act (HIPAA), the privacy of your health_information is protected by law. TEAM Corporation is required to provide you a "Notice of Privacy Practices Policy" which details your rights and how your information may be used. Please indicate below if you would like a copy.

______ Yes, I requested and received a copy of TEAM Corporation's Policy.

______ No, I do not wish to receive a copy of TEAM Corporation's Policy.

Your signature below indicates that you have read and understand this form and that you consent to receiving services through TEAM Corporation.

Client's Signature: ____ Date:________________

*Signature of Parent or Legal Guardian:____________________________________ Date: __________ (If applicable)
*By signing, affirms you have authority to present this minor for services

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