San Francisco Health Service System Employee Assistance Program
Significant Other Client Information Form – Couple Counseling

1. **Today's date** _____

2. **Your name (Last, First, M.I.)**

   _____

3. **If you are a family member or significant other of a City/County employee, complete the following:**

   I am the employee's (e.g. wife, son, partner)

   _____

   Employee's name (Last, First, M.I.)

   _____

   Last 4 of Your Social Security #

   _____

4. **Phone number** ( )_____
   May we leave a voice mail message?
   Yes ☐ No ☐

5. **Home address if different than partner's** (street address, city, zip)

   _____

   _____

   _____

6. **Highest level of education** _____

7. **Are you employed? If so where?**

   _____

8. **Person to contact in emergency**

   Name _____

   Relationship to you _____

   Phone number ( ) _____

   Address if different from yours

   _____

   _____

9. **Email Address** _____

10. **Gender**
    ☐ Female
    ☐ Male
    ☐ Other _____

11. **Your sexual orientation**
    ☐ Gay ☐ Lesbian ☐ Bi-sexual ☐ Heterosexual
    ☐ Other _____

12. **Age and gender of your dependents (if any)**

    _____

13. **Age** _____

14. **Race/ethnic origin**
    ☐ African American
    ☐ Caucasian
    ☐ Chinese
    ☐ Filipino/Filipina
    ☐ Japanese
    ☐ Latino/Latina
    ☐ Native American
    ☐ Vietnamese
    ☐ Other Asian/Pacific Islander
    ☐ Mixed race/other: _____

15. **Do you have health insurance?**
    ☐ City Plan
    ☐ Kaiser
    ☐ Blue Shield
    ☐ Other _____
    ☐ None

16. **Are you eligible for Veteran's benefits?**
    ☐ Yes
    ☐ No

CONSENT FOR SERVICES

VOLUNTARY

I, _____ voluntarily consent for evaluation, assessment, screening and/or intervention with the San Francisco Health Service System Employee Assistance Program (EAP.) I understand that 6 sessions in a 12 month period are available to me so long as it is deemed appropriate by my counselor. I understand that appointments must be scheduled in advance and that if I want to reschedule or cancel, I must call 24 hours prior to my appointment time. If I do not show up and have not cancelled, the "no show" will count as one of my 6 sessions.

CONFIDENTIALITY

I understand that records concerning the services I receive will be kept by the EAP. Professional ethics and state laws (California Welfare and Institution Code 93-292, Title 42, Sections 5328 and 5330) mandate that these records will be kept confidential. On occasion, your EAP counselor may need to communicate by electronic means. Any emails sent will be sent SECURE/encrypted.

I understand that California State Law requires that Licensed Marriage & Family Therapists break confidentiality in specific instances:

California Evidence Code 1024 states that a therapist (counselor) may break confidentiality "…if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."

Additionally, in accordance with California Law, I understand that if my EAP counselor has reasonable suspicion about child abuse, elder abuse and/or disabled or dependent adult abuse, the counselor is required by law to report to the appropriate agency(s). Therefore, if in the course of my work with the EAP counselor I reveal such information, it will be reported to the appropriate protective agency(s).

Further, I understand that under Section 215 of the Patriot Act, if an FBI agent presents a national security letter compelling my therapist's (counselor's) compliance with the Patriot Act, the therapist must provide FBI agents with any items that are requested. The therapist is prohibited from disclosing to the patient or anyone else (who could reasonably inform the patient) that the subpoenaed items were either sought or obtained.

_____

Client Initials

COORDINATION OF CARE

I understand that if I am under the care of a physician, health care provider and/or another therapist, I will need to discuss this with my EAP counselor (therapist.) To provide coordinated care, a written "Release of Information" form or "Authorization to Exchange Confidential Information" form may be required to allow the EAP counselor to talk to my other health care provider(s).

EMERGENCIES

I understand that while I am receiving services from the EAP, it I have a mental health or substance abuse emergency, I can, during normal EAP business hours (M-F 8:00am-5:00pm) contact my EAP counselor at (628) 652-4600. If a counselor is not available or if I do not desire to contact EAP, I will call 911 or go to the nearest hospital emergency room to seek services.

QUALITY OF SERVICES

I understand that getting the most out of EAP services requires that I fully participate and promptly communicate any concerns about the quality of services to my EAP counselor who will be glad to discuss it with me.

CONSENT

Your signature below indicates that you have read this "Consent for Services" and understand it. If you have any concerns or questions you would like addressed before signing this Consent for Services, please inform your EAP counselor.

NOTE: Employees seeking Telecounseling services may provide written or verbal consent.

I have read and agree to the terms of this Consent for Services:

_____ _____

Client Signature **Date**

_____ _____

Counselor Signature **Date**