IMPACT Treatment Waiver Form

If you will be continuing treatment beyond the authorized EAP sessions, please complete and review this form with your client at the conclusion of the EAP visits. The IMPACT Solutions Treatment Waiver Form should be returned to IMPACT Solutions with the Care Management Form Part C; your final billing. Please copy as needed.

Treatment Waiver Form

Attention Affiliate Provider: This form must be completed with client and submitted to IMPACT Solutions with the Care Management Form Part C whenever a self-referral is made.

Date:_____

IMPACT Solutions Affiliate Provider Name:_____

Client Name:_____Authorization #:_____

IMPACT Solutions EAP allows its Affiliate Providers to refer to themselves, or self-refer. However, to protect our clients from a potential conflict of interest, we require that this Treatment Waiver Form is provided, explained and signed by our clients requesting services beyond the EAP. To ensure that the client is empowered with choices, IMPACT Solutions EAP requires in all self-referral situations, the Affiliate Provider offer two additional referrals (when feasible) other than themselves or any other person, or organization where they may have financial interest, before asking the client to sign off. Please list them below:

- Referral #1: _____Phone Number: (___)_____-_____
- Referral #2: _____Phone Number: (___)_____-_____

I am requesting to continue counseling beyond my EAP benefit with the above named IMPACT Solutions Affiliate Provider. I understand that IMPACT Solutions EAP requires its Affiliate Providers to provide at least two additional referrals (when feasible) to other clinicians or services for which they have no financial interest, as that type of situation may pose a conflict of interest for me. I understand that I am not obligated to use any of these resources or continue seeing the Affiliate Provider. I understand that I will be responsible to determine if a provider and/or a particular service are covered by my health insurance benefit plan. I understand that I will be responsible for all services rendered beyond the scope of my EAP and that I can contact IMPACT Solutions for additional resources/referrals at any time.

_____ _____

Client Signature Date

01-2013

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