OptimaHealth

Treatment Waiver Form

Client Name____

Name of Provider____

In the event that our clients need long term counseling, mental health treatment, or therapy, we prefer that the EAP Affiliate Provider refer to other professionals or services covered by the client's insurance or available in the community. We recognize, however, that at times, other resources may not be available or our clients may prefer to continue service with the Optima EAP Affiliate Provider.

Optima EAP allows its EAP Affiliate Providers to refer to themselves, or "self-refer". However, to protect our clients from a potential conflict of interest, we require this "Treatment Waiver Form" is provided, explained and signed by our clients 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 client is empowered with choices, Optima EAP requires in all self-referral situations, the EAP Affiliate Provider offer two additional referrals other than themselves or any other person, or organization where they may have financial interest, before asking the client to sign off. Please list providers below.

Referral: ______________________________ Phone Number: _______________

Referral: ______________________________ Phone Number: _______________

I ______________________________ am requesting to continue counseling beyond my EAP benefit with ____. I understand that Optima EAP requires its EAP Affiliate Providers to provide at least two additional referrals 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 EAP 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 benefit.

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Client Signature Date