Freedom of Choice Affidavit

Must be Signed by Any Client Continuing Therapy with Assessing Provider After EAP Services are Completed

I, _____, verify that I have been offered a referral to at least two (2) additional counseling resources as part of my EAP provider's assessment recommendations. Instead, I have decided to seek ongoing assistance through my EAP provider's private psychotherapy or clinic practice. My signature below also verifies my understanding that in electing to seek treatment with the psychotherapist below, or the clinic they are associated with, I have entered into a direct payment relationship with that provider. Therefore, Empathia, Inc. will no longer pay or be responsible for the services provided by this provider. ***I understand that I am solely responsible for determining if the services of this provider are covered under my medical insurance plan.***

_____

Client Signature Date

_____

Clinician Signature/Witness Date

PROVIDER: Please list the two alternate treatment provider options below. These providers must be outside of your practice and not affiliated with any individual, group, or treatment facility in which you have a financial interest. These providers should be covered through the client's insurance plan.

Provider Name/Clinic Phone Number

1. _____(_____)_____

2. _____(_____)_____

Please retain for your records.