EMPATHIA

Empathia Pacific, Inc. Provider Self-Referral Instructions

Empathia Pacific, Inc. CLIENT COMPANIES:

Self referral is permitted when the provider has ensured that the client would incur no financial hardship and has been offered at least two alternate referrals making use of the client's insurance or a community-based resource. In addition, a self-referral should not be offered if there is a significant possibility of a conflict of interest with the client's company or when there is the high potential for litigation with the company.

The attached Freedom of Choice Affidavit ***must*** be completed and maintained in the client's file to be provided to Empathia Pacific, Inc. upon request.

FREEDOM OF CHOICE AFFIDAVIT

MUST BE SIGNED BY ANY CLIENT CONTINUING IN TREATMENT WITH THE ASSESSING PROVIDER AFTER EAP SESSIONS ARE COMPLETED

I, _____, verify that I have been offered referrals to at least two (2) other ongoing treatment resources as part of my EAP provider's assessment recommendations. Instead, I wish to obtain ongoing treatment through my EAP provider's private psychotherapy practice or clinic practice. My signature below verifies my understanding that in electing to seek treatment with the psychotherapist below or clinic that they are associated with, I have entered into a direct payment relationship with that provider and that ***any services provided will not be covered by the EAP***. Therefore, Empathia, Inc., and/or Empathia Pacific, Inc. will no longer pay or be responsible for the services provided by this provider. Further, ***I understand that I am solely responsible for determining whether the services of this provider are covered under my medical insurance plan.***

Client name (print)	Client signature	Date

Provider name (print)	Provider signature	Date

PROVIDER: Please list two alternate provider options below. These providers must be outside of your practice and not affiliated with any group, individual, or 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