

MehraVista Health

Supervisory/Mandatory Form

WELCOME: Your employer has retained MehraVista Health (MVH) to provide employee assistance program (EAP) services to its employees and covered dependents. MVH contracted counselors are available to talk to you about any concern you may have. **THERE IS NO CHARGE FOR THE INITIAL ASSESSMENT AND/OR REFERRAL TO YOUR COUNSELOR.**

If you have been encouraged by your employer to use our services due to a concern or a job performance problem, then the nature of your problem or the assistance involved will not be discussed with your employer. Only the following will be shared:

- **Whether or not you kept your appointment**
- **Whether or not your counselor recommended further assistance- not the nature of the assistance**
- **Whether or not you followed the recommendation**
- **When you cease to receive services**

If you have any questions regarding the above, please talk with your counselor.

Our counselors can assure you confidential treatment of your personal and medical records. Exceptions of confidentiality are with your informed and written consent. In addition, all counselors must report:

- **Any incident or knowledge of suspected neglect, physical or sexual abuse of children to the Department of Children and Families. Maltreatment of vulnerable adults as specified in the Vulnerable Adults Act.**
- **If there is a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person, our counselors are required to notify the appropriate authorities, workers, the potential victim or your family.**
- **Upon court order, specified information to the court.**
- **Information that may lead the counselor to believe that an employee who is applying for a security clearance, is a serious security risk according to government guidelines. This information will be reported to security at your place of employment.(Dept of Defense and Department of Energy only).**

REFERRALS: During the course of counseling, it may be recommended that you seek services from another agency or professional. It is your responsibility to act on recommended referrals.

I have read and understand the limits of confidentiality regarding my participation in EAP services. My signature below indicates my consent for services.

Employee Signature

Date

Counselor Signature

Date