

## Documentation/Signature Page

Whenever possible, appointments are confirmed a business day in advance. If you DO NOT want your appointment confirmed, please check below.

\_\_\_\_\_ No, do not confirm my appointments.

### Please Initial

\_\_\_\_\_ I understand all information given to Matthew McNally and the staff of Solutions EAP is confidential. Information given is used to help determine the type of service needed. I understand that if at any time I am uncomfortable providing specific information, I can ask and the necessity of the information will be explained to me.

\_\_\_\_\_ I have reviewed the points in the Participant Orientation and Client Rights documents of Matthew McNally, MA, CI. Any questions I have raised have been answered.

\_\_\_\_\_ I understand if I fail an appointment (do not cancel within 24 hours) I will be charged a fee of \$40.00 for full sessions or \$20.00 for half sessions and that the fee will not be reimbursed by insurance. I will be financially responsible for the fee.

\_\_\_\_\_ I understand I will be held responsible for additional services such as reports, court appearances, depositions and school consultations.

\_\_\_\_\_ I have received a copy of the Client Grievance Procedure.

\_\_\_\_\_ I acknowledge that I have received a copy of the Notice of Privacy Practices from Solutions Employee Assistance Program, a subsidiary of the Safety Council of SWLA.

\_\_\_\_\_ I verify I am eligible for Solutions EAP contracted services and I am (or my immediate family member is) a direct employee of the company I listed on the Client Questionnaire.

\_\_\_\_\_ Date: \_\_\_\_\_  
Client #1 Signature

\_\_\_\_\_ Date: \_\_\_\_\_  
Client #2 Signature (if applicable)

\_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_ Date: \_\_\_\_\_  
Therapist