

CLIENT INFORMATION FORM

SECTION I EMPLOYEE INFORMATION ONLY

Employer & Location (City & State):		Division/Department:		Authorization #: (CAI Office Use Only)	
Employee Name:		Employee SS#:		Employee Date of Birth:	
1. Age:	Sex: Male Female	Home Phone: ()		Work Phone: ()	
2. Home Address:			City:	State:	Zip:
3. Case Status:		4. Ethnic Origin:		5. Marital Status:	
<input type="checkbox"/> New <input type="checkbox"/> Reopened <input type="checkbox"/> Last Time Seen at CAI: <input type="checkbox"/> Same Problem <input type="checkbox"/> New Problem		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
				6 Education: (highest completed)	
				<input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> Technical <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
7. Information Source:		8. Referral Source:		9. Employee's Job Category:	
<input type="checkbox"/> Home Mailing <input type="checkbox"/> Brochure/Poster <input type="checkbox"/> Training Session <input type="checkbox"/> Family Member <input type="checkbox"/> Supervisor <input type="checkbox"/> Co-Worker <input type="checkbox"/> Other		<input type="checkbox"/> Self Referral <input type="checkbox"/> Supervisory Referral Suggestion Required <input type="checkbox"/> Family Initiated <input type="checkbox"/> Company Wellness/Medical Department		<input type="checkbox"/> Executive Management <input type="checkbox"/> Professional/Technical <input type="checkbox"/> Sales/Marketing <input type="checkbox"/> Clerical <input type="checkbox"/> Maintenance <input type="checkbox"/> Labor Manufacturing	
				10. Employee Status:	
				<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Downsized <input type="checkbox"/> Terminated <input type="checkbox"/> Voluntarily Left Company	
				Date: _____	
				Length of Service: Years _____ Months _____	

SECTION II NON-EMPLOYEE INFORMATION ONLY

Name:	Relationship to Employee:	SS#:	D.O.B./Age:	Ethnicity (see#4)	Sex: Male Female
Home Address:			City:	State:	Zip:
Case Status: New		Reopened/Last Time Seen at CAI: _____		Problem (if reopened): New Same	
Name:	Relationship to Employee:	SS#:	D.O.B./Age:	Ethnicity (see#4)	Sex: Male Female
Home Address:			City:	State:	Zip:
Case Status: New		Reopened/Last Time Seen at CAI: _____		Problem (if reopened): New Same	
Name:	Relationship to Employee:	SS#:	D.O.B./Age:	Ethnicity (see#4)	Sex: Male Female
Home Address:			City:	State:	Zip:
Case Status: New		Reopened/Last Time Seen at CAI: _____		Problem (if reopened): New Same	

SECTION III PROVIDER USE ONLY

Open Date:	Counselor Name:	Affiliate Company Name/Location:																																																																																		
<p style="text-align: center;"><u>Record of Face to Face Contacts: (Please Refer to *Codes)</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Session #</th> <th>Date</th> <th>*With Whom</th> <th>#Attending</th> <th>Cancellation</th> <th>No Show</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table> <p style="text-align: center;"><u>Other Contacts</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table> <p style="text-align: center;"><u>6 Month Aftercare Case Follow-up</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table> <p style="text-align: center;"><u>*Codes (Contact With Whom)</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>01 Employee</td> <td>05 Supervisor</td> <td>09 CD Tx Agency</td> </tr> <tr> <td>02 Dependent</td> <td>06 Employee Relations/HR</td> <td>10 Community Agency</td> </tr> <tr> <td>03 Employee & Partner</td> <td>07 Benefits</td> <td>11 Counselor/Therapist</td> </tr> <tr> <td>04 Family</td> <td>08 Psych Tx Agency</td> <td>12 Physician/PCP</td> </tr> </table>			Session #	Date	*With Whom	#Attending	Cancellation	No Show	1						2						3						4						5						6						7						8																						01 Employee	05 Supervisor	09 CD Tx Agency	02 Dependent	06 Employee Relations/HR	10 Community Agency	03 Employee & Partner	07 Benefits	11 Counselor/Therapist	04 Family	08 Psych Tx Agency	12 Physician/PCP
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<p style="text-align: center;"><u>Problem Classification</u> (Select and Indicate <u>one</u> Primary (1) and <u>one</u> Secondary (2) problem.)</p> <table style="width: 100%;"> <tr> <td>___ 1. Emotional</td> <td>___ 5. Familial</td> <td>___ 8. Legal</td> </tr> <tr> <td>___ 2. Drugs</td> <td>___ 6. Traumatic Event or Loss</td> <td>___ 9. Financial</td> </tr> <tr> <td>___ 3. Alcohol</td> <td>___ 7. Occupational</td> <td>___ 10. Other: _____</td> </tr> <tr> <td>___ 4. Relationship Problems</td> <td></td> <td></td> </tr> </table> <p style="text-align: center;"><u>Case Disposition</u></p> <p>1. Date of Closing _____</p> <p>2. TX Provided: (Check/Complete all that apply)</p> <p>___ a. EAP EAP Treatment Successfully Completed? Yes ___ No ___</p> <p>___ b. Outpatient Psych Tx, Therapist Name/Co. _____</p> <p>___ c. Outpatient CD Tx, Agency Name _____</p> <p>___ d. Inpatient Psychiatric Treatment, Agency Name _____</p> <p>___ e. Inpatient CD Treatment, Agency Name _____</p> <p>___ f. Community Resources (e.g. self-help, elder care, etc.) _____</p> <p>___ g. Other: _____</p> <p>3. Referred to CAI Managed Care? Yes ___ No ___</p> <p style="padding-left: 40px;">___ MC Department Verbally Informed</p> <p style="padding-left: 40px;">___ EAP Referral Form Completed</p> <p>4. Did Client receive a Satisfaction Survey Form? Yes ___ No ___</p>			___ 1. Emotional	___ 5. Familial	___ 8. Legal	___ 2. Drugs	___ 6. Traumatic Event or Loss	___ 9. Financial	___ 3. Alcohol	___ 7. Occupational	___ 10. Other: _____	___ 4. Relationship Problems																																																																								
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SECTION IV

STATEMENT OF UNDERSTANDING

FEES

Cameron and Associates, Inc. (CAI) is a private EAP/Managed Behavioral Health Care firm offering consulting, assessments, referrals for long-term counseling, in-patient admissions and confidential short-term counseling to employees and their eligible dependents. EAP counseling services are offered to eligible members at no cost. The EAP benefit has been prepaid by your employer, _____ and offers up to a maximum of _____ counseling sessions per primary problem. Clients are seen by appointment. If you are unable to keep an appointment, it is required that you give at least 24 hours notice of cancellation in order to avoid having it counted as one of your total allowed number of sessions.

Referrals to outpatient and in-patient counseling may be recommended to resolve problems that are not covered under the EAP. Any costs involved for these services outside of the EAP are the client's responsibility. There may be coverage for these outside services under your medical benefit plan.

PRIVACY

Information concerning the use of CAI services is not given to anyone outside of Cameron and Associates, Inc. (CAI) without your permission, unless it is required by law. Certain states require that CAI staff assume the responsibility for reporting to appropriate parties when a person is in danger to him or herself, to others, or when child or adult abuse/neglect is involved.

SELF-REFERRAL

If an employee or family member initiates a request for assistance, the contact will remain confidential, unless there is individual written permission.

SUPERVISOR REFERRAL

If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive drug screening, the supervisor will be notified whether or not the employee has kept the appointment(s).

VOLUNTARY PARTICIPATION

Use of CAI's services is voluntary. It is the client's decision to use, or not to use, the services available. In some cases, as noted above, your employer may require assessment and follow through with the recommendations made by staff as a condition of employment, or as a part of the company's substance abuse policy.

SECTION V

ACKNOWLEDGEMENT OF PRIVACY POLICIES

I have received a copy of Cameron and Associates, Inc.'s Notice of Privacy Policies.

SECTION VI

PATIENT AGREEMENT FOR COMMUNICATIONS

I understand that as part of my Mental Health Care, CAI may need to contact me for the purpose of confirming an appointment or giving me additional information.

I understand that CAI will use the minimum necessary information needed when they communicate with me. I understand that I can revoke or amend this agreement at any time. Any revocation or changes will not apply to communications already complete.

I hereby authorize CAI to contact me in the following manner:

Please choose one:

Home: _____ Mobile: _____ Office: _____ Email: _____

ACKNOWLEDGEMENT

By signing the **Client Information Form**, I understand and acknowledge its content beginning with sections I-II and sections IV -VI, which includes the "Statement of Understanding", "Acknowledgement of Receipt of Privacy Practices" and "Patient Agreement for Communications".

(Please print Employee/Member name)

(Employee/Member Signature)

(Parent/guardian if under 16 years of age)

(Date)

PROVIDER INFORMATION/INSTRUCTIONS

Please submit this Client Information Form along with a **HCFA 1500 Claim Form for billing. (CAI no longer accepts CAI invoices or personal invoices). Mail forms to:

CAMERON AND ASSOCIATES, INC., ATTN: CLAIMS DEPT., 6100 LAKE FORREST DR., SUITE 550, ATLANTA, GA 30328

**** Claims must include the authorization number. (Prior Authorization is required for all Services)**

Please give all clients the following forms**: † Satisfaction Survey Form ...Notice of Privacy Policies Brochure

**** These forms are not required for submission of payment, but are required to be given to the member(s).**

All Providers will need to submit an Outpatient Treatment Plan Form (OTR) after the initial authorized sessions to request additional sessions, coverage or discharge. Please Fax the completed OTR form to (404) 459-7147 or mail to CAI. You will be notified in writing of approval or denial of additional sessions within 10 business days of submitting the completed OTR form.

For further information, assistance or Authorization please Contact CAI at: **(404) 843-3399/ (800) 334-6014/ Food Lion (800) 387-9919.**