KEPRO
INTELLIGENT VALUE

Consent to Self-Referral Form

Dear Clinician:

You have asked to continue to see an EAP client for on-going clinical services that may or may not be covered by their health plan. Please have your KEPRO referred client complete this form at the conclusion of their allotted EAP sessions if they decide to continue care with you. Once completed, please fax this form to 866-480-8341 or mail it to the below address.

A self-referral may be appropriate in these situations:

- The client specifically requested to continue treatment in your office, you have provided them with two additional referrals, and they understand their options.
- Other local clinicians are not available at this time and a delay in treatment could result in negative consequences for this client.
- The client's presenting problem matches your area of expertise.
- A referral to a third party would create a barrier, hindrance or serious disruption of treatment.
- You are the only clinician within a 30 mile radius with training and competence in treating the client's presenting problem.

Client Name:_____ Client Case Number:_____

EAP Clinician's Name:_____

I plan to continue in counseling with the above named EAP Clinician and understand that the EAP covers an allotted number of counseling sessions; any visits beyond that number are outside the scope of the EAP benefit. If I choose to continue to see this clinician beyond my allotted sessions, I understand that KEPRO EAP will not be responsible for the cost of these sessions. The clinician has provided me with two alternate referrals, has educated me about my treatment options and I have made an informed decision.

I also understand that the clinician is (check the one that applies):

☐ A participating provider with my insurance plan
☐ Is NOT a participating provider under my insurance plan

_____ _____
Client Signature *Date*

_____ _____
EAP Affiliate Signature *Date*