



HEALTH AND HUMAN SERVICES GROUP
23392 Madero Road, Suite L
Mission Viejo, California 92691
800-275-7460; FAX 949-855-7575

**U.S. Department Of Justice
Drug Enforcement Administration**

CLINICIAN SELF-REFERRAL DISCLOSURE FORM

The DEA EAP only provides you and/or your family with up to 6 counseling sessions to help resolve your life circumstance or occupational problems. After you have completed the EAP sessions you are discharged from the EAP program and your case is closed. One of the options available to you or your family is to continue counseling with the therapist you worked with during the EAP sessions.

Your decision to continue in counseling with the therapist is made by you or your family member without coercion or undue influence from the EAP therapist or HHSG, and does not obligate the DEA EAP financially. Federal law requires that you be informed of any financial interests or investments involving the therapist and HHSG. HHSG has no financial interest or investment in the outpatient services performed by _____ after discharge from the DEA EAP. However, _____ is the owner of the clinic you will receive outpatient services from and will profit from those services.

You have the option to receive outpatient services, after discharge from the EAP, elsewhere and if you require assistance locating a different therapist than the one you have been working with please call the EAP at 800-275-7460,

Please sign the statement below indicating that you understand your options for continued services beyond those authorized by the DEA EAP.

I agree to receive outpatient services, beyond those authorized by the DEA EAP, from _____. I understand that my medical benefits plan and I will pay for these services. I also understand that HHSG has no vested financial interest in _____ practice. Finally, I understand that _____ has invested in this clinic and will profit from all services rendered to me on an outpatient basis.

Date: _____ Client Signature: _____

Client Printed Name and Address: _____

NOTE: Clinician must have this form completed by all clients wishing to continue a therapeutic relationship with you after terminating services rendered through the DEA EAP. Clinician understands that all charges for continued services are the responsibility of the client and not DEA or HHSG.

CLINICIAN TO FAX COMPLETED FORM TO HHSG (949)-855-7575 FOR APPROVAL BEFORE SELF-REFERRAL

**Approval Granted
Denied**

Ms. Elyse Sharpe, EAP Administrator

Date

HHSG/DEA Form# 8