KAREN ROSE, MFT

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Self-Referral Waiver

I have been receiving Employee Assistance Program (EAP) services from Karen Rose, MFT, LPCC through EAP Consultants.

I understand that it is my provider's judgement that my issues cannot be resolved through brief counseling or other services available through the EAP and that I therefore need treatment beyond the services available through EAP.

I understand that EAP Consultants has the capability to refer me to an appropriate clinician in my community to furnish ongoing treatment, however, I choose to see this provider in her private practice for ongoing treatment. I understand that I will be responsible for the payment for all services provided by the provider after the
last EAP session date ____.

I understand that if I desire reimbursement under my regular insurance benefit plan, I am responsible for determining whether or not the treatment rendered by the provider will be covered under the benefit plan and will provide full intake information along with a copy of the front and back of my insurance card.

I give my permission for a copy of this form to be sent to EAP Consultants.

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Signature

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Print Name

____
Date