Ceridian LifeWorks Services

TREATMENT WAIVER FORM

Case # _____ Affiliate Provider Name: _____

When clients are referred for Employee Assistance Program (EAP) services by Ceridian LifeWorks, affiliate providers are expected to see them for EAP services only. When clients need counseling, mental health treatment, or therapy beyond the number of EAP sessions available, Ceridian prefers that affiliate providers refer to other professionals or services covered by the client's insurance or available in the community. However, in many cases other resources are not available, and clients may request to continue with EAP providers who also offer ongoing mental health services.

Ceridian will permit affiliate providers to refer clients to themselves when this "Treatment Waiver Form" has been explained and signed by their clients. Affiliate providers must give clients two additional referrals other than themselves, or any other person/organization with which they have a financial interest. Client signatures on this Treatment Waiver Form help to ensure that they are empowered with choices and protected from potential conflicts of interest.

Affiliate Provider: This form must be completed if you, or someone within your group practice, continue to see this client through his or her insurance benefits or private pay after the EAP assessment is complete. Please identify two referrals below and give them to the client at the **final** EAP assessment session if you are referring into insurance benefits or private pay.

Referral:		Phone	
Referral:		Phone	

Client: Please complete this request and indicate your understanding with your signature.

I, _____ (print your name), am requesting to continue counseling beyond me EAP benefit with _____ (print counselors name), a Ceridian LifeWorks Services EAP Affiliate Provider. I understand that Ceridian requires its EAP affiliate providers to provider at least two additional referrals to other clinicians or services for which they have no financial interest. I understand that I am not obligated to use any of these resources or continue seeing Ceridian's Provider. I understand that I will be responsible to determine if a provider and/or a particular service is covered by my health insurance benefits plan. I understand that I will be responsible for all services rendered beyond the scope of my EAP benefit.

_____ _____

Client Signature Date

Please keep completed form on file.