Data Intake Sheet

Client Information
(Person presenting for service)

Client Name:____**D.O.B.:** _______________________

Home #:_______________________**Cell #:**_______________________**Work #:** ______________________

Safe Contact Number: **Home:**___ **Work:**___ **Cell:**___ **No Preference:**___

Home Address: _____________________________ **City:** ____________ **State:** _____ **Zip:** ___________

Emergency Contact Name/Relationship____

Emergency Contact Phone #: _______________________

Person whose organization provides TEAM Corporation services

Union Member or Employee Name: ____

Union/Employer: ____

Reason for Visit

Please briefly describe your reason for today's visit:

Please turn this form over and read and sign the Statement of Understanding

TEAM Corporation
Roseville Office Plaza, 1970 Oakcrest Avenue - Suite 200, Roseville, MN 55113
Duluth Labor Temple, 2002 London Road - Suite 95, Duluth, MN 55812
team@team-mn.com
Main: 651.642.0182 | Duluth: 218.727.8589 | Toll Free: 800.634.7710 | Fax: 651.642.1809

STATEMENT OF UNDERSTANDING

TEAM Corporation is an Employee Assistance Program (EAP) that provides an assessment of life problems, short-term counseling, referrals, follow-up services and consultation. EAP services are available to members/ employees and their dependents. These services are provided at no cost through your organization.

Limits of Confidentiality

All contact with TEAM Corporation is strictly confidential within the limits of the law. As mandated reporters, there are certain circumstances in which we are required to report information. EAP counselors must report if you share information about:

- Abuse or neglect of a minor child
- Abuse or neglect of a vulnerable adult
- Prenatal exposure to a controlled substance for a non-medical purpose
- Sexual misconduct perpetrated by another mental health or medical professional
- Imminent or expectable risk to yourself, i.e., suicidal
- Imminent or expectable risk to another person, i.e., homicidal

TEAM Corporation may also be obligated to comply if a court order demands that we release information.

Minor clients should be aware that if they are not emancipated, their custodial parent/s or guardian/s have legal rights to information about their child's condition, diagnosis, progress, and medical records.

Referrals

In the event a client needs longer term treatment, TEAM Corporation will refer them to their health plan and the client will be responsible for any applicable fees or charges. These referrals are suggestions; the decision to use or not to use these resources is at your discretion.

Federal Guidelines on Confidentiality:

Under the Health Insurance Portability and Accountability Act (HIPAA), the privacy of your health information is protected by law. TEAM Corporation is required to provide you a "Notice of Privacy Practices Policy" which details your rights and how your information may be used. Please indicate below if you would like a copy.

_______Yes, I requested and received a copy of TEAM Corporation's Policy.

_______No, I do not wish to receive a copy of TEAM Corporation's Policy.

Your signature below indicates that you have read and understand this form.

Client's Signature:____**Date:** _____________________

***Signature of Parent or Legal Guardian:**___________________________________**Date:** ______________

(If applicable) ***By signing, affirms you have authority to present this minor for services.**

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