Date: ____________________

REQUEST FOR EAP SERVICES

Company Name: ____________________________

Billing Address: ____________________________

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Employee Name: ____________________________ **Number of Visits:** _____

Cost:	Initial Session	$250.00 per hour
	Each Follow-up Session	$125.00 per hour

I authorize Parkview Employee Assistance Program to provide counseling services to the above named employee as is related to mental health, substance abuse or any related concerns necessary for this referral. I understand that the company has access to the number of visits only; all other information is confidential to the patient relationship.

Parkview Employee Assistance Program shall have sole, exclusive and final authority to determine record keeping requirements. All records shall remain the sole property of Parkview Employee Assistance Program.

I also authorize payment to Parkview Employee Assistance Program and payment is due within thirty (30) days from date of invoice.

___________________________________ ________________________________

Authorized Signature Title

____

Authorized Date

FAX TO: (260) 266-8035
Parkview Employee Assistance
3948 New Vision Drive, Suite E, Fort Wayne, IN 46845
Phone (260) 266-8060 or toll free 1-800-721-8809