OUTCOMES INC.
BUILDING PATHWAYS TO WELLNESS
COUNSELING · EMPLOYEE ASSISTANCE · CONFLICT RESOLUTION

Client Face Sheet

Client Account #

FOR OFFICE USE ONLY:
☐ CAP-EAP ☐ Insurance ☐ Self-pay ☐ NONCAP-EAP ☐ Relative/Significant Other

Today's Date:

Patient Name: | **DOB**: | **SSN**: | **Age**:

Address: | **City**: | **ST**: | **Zip**:

Home Phone#: **Messages Ok?** ☐ Yes ☐ No | **Work Phone#**: **Messages Ok?** ☐ Yes ☐ No | **Mobile Phone#**: **Messages Ok?** ☐ Yes ☐ No

Employer: | **Occupation**: | **Hire Date**:

Gender: ☐ Male ☐ Female | **Language**: ☐ English ☐ Spanish ☐ Both ☐ Other: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed

Ethnicity (optional): ☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other:____

Education Completed: ☐ Grades 1-12 ☐ High School or Equivalent ☐ College 1-4 years ☐ College Graduate ☐ Graduate School

For EAP Employees Only

Relationship to Client: ☐ Self ☐ Parent ☐ Spouse/Partner ☐ Other:____

Referred By: ☐ Self ☐ Co-worker ☐ Supervisor Mandated ☐ Family Member ☐ Supervisor Recommended

How did you hear about EAP Program? ☐ Brochure/Poster/Literature ☐ Co-worker ☐ Employee Orientation ☐ Other: ______________________________________

Status: ☐ Salaried ☐ Hourly ☐ Commissioned | **Hire Date**:

Job Category: ☐ Administration/Management ☐ Sales/Marketing ☐ Operations/Maintenance ☐ Professional/Technical ☐ Clerical/Support ☐ Labor/Manufacturing ☐ Other: ______________________________

Identify work performance problems (mark at least one): ☐ Absenteeism/Tardiness ☐ Safety/Security ☐ Positive Alcohol/Drug Test ☐ Quantity/Quality of Work ☐ N/A-Other Family Member ☐ No Work Performance Problem

For Self-Pay Clients Only

Income: ☐ $0 - 12,999 ☐ $13,000 - $19,999 ☐ $20,000 - $29,000 ☐ $30,000 - $39,999 ☐ $40,000 - $49,999 ☐ $50,000 & Above

For Insurance and EAP Clients Only

Insurance or EAP Company name: __________________________________ Policy #______________________________

Insurance company contact phone # _________________________________ Group # _____________________________

Insurance and EAP Clients Only

By signing below, I am authorizing OUTCOMES, INC. to release any information and benefits necessary to process my insurance claim and/or EAP invoice for services provided by OUTCOMES, INC. and authorize direct payment to OUTCOMES, INC.

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