MYgroup
McLAUGHLIN YOUNG

Self-Referral Authorization Form

The following section is to be completed by the provider at the completion of initial assessment:

Please list two alternate treatment provider options below. These providers must be outside of your practice and not affiliated with any individual, group or treatment facility in which you have a financial interest.

	Provider Name/Clinic	Phone Number
1.		
2.		

Clinician's Signature: _____ **Date: _____**

The following section is to be completed by the client:

I, (Client's name) _____, verify that I have been offered at least two other counseling resources as part of my EAP assessment. Instead I have decided to remain with my current counselor. My signature below also verifies my understanding that in electing to seek treatment beyond the EAP, I have entered into a direct payment relationship with that provider. Therefore, McLaughlin Young Employee Services is not financially responsible for the services provided by the private practice. I understand that I am solely responsible for determining if the services of the clinician are covered under my medical insurance plan.

Client Signature (or parent/guardian): _____

Date of Birth: _____ **Today's Date: _____**

Reason for accepting self-referral:

☐ Clinical Expertise
☐ Client Preference
☐ Convenience of Location
☐ Scarcity of Available Resources
☐ Other:_____