

Freedom of Choice Affidavit

Must be signed by any client continuing therapy with assessing provider after EAP services are completed.

I, _____, verify that I have been offered a referral to at least two (2) other counseling resources as part of my EAP assessment. Instead, I have decided to seek ongoing assistance through my **DOR** Provider's private psychotherapy practice. My signature below also verifies my understanding that in electing to seek treatment with the psychotherapist below, I have entered into a direct payment relationship with that provider. Therefore, **DOR** will no longer pay or be responsible for the services provided by this psychotherapist. I understand further that I am solely responsible for determining whether the services of this psychotherapist are covered under my medical insurance plan.

Client Signature _____ Date _____

Clinician's Signature/Witness _____ Date _____

Provider: Please list the 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. _____	() _____