GUNDERSEN HEALTH SYSTEM
EMPLOYEE ASSISTANCE PROGRAM

FREEDOM OF CHOICE AFFIDAVIT

After my EAP consultation with _____
(Name of EAP Consultant)
Of _____, an Affiliate Provider for Gundersen Health
(Name of Agency) (City) (State)
System's EAP (GHS-EAP), I have decided to seek ongoing assistance with the Affiliate Provider. I have been presented with at least two other treatment options, and the relative advantages and cost differences of each alternative were clearly explained. My signature below verifies my understanding that in electing to seek treatment with the provider below, I have entered into a direct payment relationship with that provider. I understand that I will no longer be receiving services under the benefits of GHS-EAP.

_____
Client Name (Please Print)

_____ _____
Client Signature Date

_____ _____
Clinician's Signature/Witness Date