

DATE: _____

The Sand Creek Group
610 North Main, Suite 200
Stillwater, MN 55082

**BILLING FORM FOR
PROVIDER**

EMPLOYEE Name: _____	EMPLOYER	Make Checks Payable to: Name: _____ Address: _____ _____ _____ Phone: _____ E-Mail: _____
DOB: ____ / ____ / ____		

CLIENT (If different from employee) Name: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Relationship to Employee: <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Self	Permission to Call: <input type="checkbox"/> Yes <input type="checkbox"/> No Home Phone: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Work Phone: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

PROBLEM AREAS: (Check all that apply, circle Primary Problem)

Legal Physical or Sexual Abuse Career Mental Health (Specify) _____

Individual Financial Crisis Family Medical Specify: _____

Grief and Loss Alcohol/Drug: concerns of employee

Alcohol /Drug Concerns of Family (Partner or Child) Other (Specify) _____

Couple Problem/Relationship Issue

EAP INVOICE: (For authorized sessions) Session Date ____ / ____ / ____ \$ ____ # Persons ____ Session Date ____ / ____ / ____ \$ ____ # Persons ____ Session Date ____ / ____ / ____ \$ ____ # Persons ____ Session Date ____ / ____ / ____ \$ ____ # Persons ____ Session Date ____ / ____ / ____ \$ ____ # Persons ____ Session Date ____ / ____ / ____ \$ ____ # Persons ____	ACTION TAKEN BY PROVIDER <input type="checkbox"/> Counseling only, no other referral <input type="checkbox"/> Referral to another provider/community resource _____ <input type="checkbox"/> Case remains open. <input type="checkbox"/> Case Closed. Date: _____
---	---

I hereby authorize _____ to disclose to Sand Creek Group Ltd. information contained in this report for the purposes of billing and program oversight. I understand my records are protected and cannot be disclosed without my written consent, unless otherwise specified in State and Federal data privacy laws, regulations and statutes that apply to this information. I also understand that I may revoke this consent at any time. Without taking any further action, my consent will expire one year from the date of my signature. Date upon which this consent expires: _____

Signature of Client: _____ Date: _____

Signature of Counselor: _____ Date: _____

Please submit this form to the Sand Creek Group, Ltd. at the above address NO LATER THAN 30 DAYS AFTER THE LAST SESSION DATE FOR REIMBURSEMENT. Phone: 651.430.3383 or 800.632.7643 Fax: 651.430.9753. Please call with any questions. Thank you for your service.