Ascension WI EAP

Freedom of Choice Affidavit

I _____, verify that I have been offered at least two referral recommendations as a part of my EAP assessment and that I have decided to seek ongoing assistance through my Ascension WI EAP affiliate's private practice.

My signature below also verifies my understanding that in electing to seek treatment with the professional named below, I have entered a contractual relationship with the provider. Ascension WI EAP is no longer responsible for the services provided.

Further, I am aware that no further services provided through Ascension WI EAP affiliate's private practice are covered by Ascension WI EAP and that I am solely responsible for determining if services are covered under my medical insurance benefit plan.

CLIENT SIGNATURE:_____ DATE:_____

AFFILIATE SIGNATURE:_____ DATE:_____

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Ascension