



EAP LIFESTYLE MANAGEMENT, LLC
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Dear Potential Affiliate Provider:

Thank you for your interest in becoming an affiliate provider for EAP Lifestyle Management, LLC. Please complete the following documents and fax or mail them back to our office. Also, include your license, liability insurance and resume. Upon receipt of the supporting documents, EAP Lifestyle Management, LLC will send you an agreement to sign and return to us.

If you have any questions please do not hesitate to contact us.

Sincerely,

EAP Lifestyle Management, LLC

HIPAA Affiliate Provider Agreement

This agreement is between EAP Lifestyle Management, LLC (EAP) and _____ (Local Provider). This agreement is a supplement to all other agreements between EAP and Local Provider, and all terms in other agreements are not directly addressed herein remain in full force and effect.

Familiarity with privacy protection rules

Local Provider represents to EAP that Local Provider is familiar with the HIPAA Standards for Privacy of Individuality Identifiable Health Information (Privacy Rule) as contained in various federal statutes and administrative regulations. Local Provider certifies to EAP that Local Provider has policies and procedures already in place that are in fully compliance with the Privacy Rule, and that Local Provider's staff has been given appropriate training regarding same.

Privacy Protection Officer

Local Provider represents to EAP that it has an individual that is ultimately responsible for insuring Local Provider's compliance with the Privacy Rule. Local Provider certifies to EAP that individual to be _____ (Name) and that this individual may be contacted by EAP as follows _____ (address, phone number, etc). Local Provider certifies that will immediately notify EAP of any changes in the above information.

Contact with EAP on Privacy Issues

Local Provider certifies that in the event any Privacy Rule-related issue arises regarding any patient or entity relating to EAP. Local Provider will immediately notify EAP by contacting (by fastest means available) Patricia Vanderpool, EAP Lifestyle Management, LLC, 1048 Stanton Road, Suite F, Daphne, AL 36526, 251-621-530. Local Provider agrees to cooperate with EAP in investigation and resolution of any such issue.

Indemnification

Local Provider agrees to indemnify and hold EAP harmless from the consequences of any Privacy Rule Violation or failure by Local Provider that results in any loss to or payment by EAP.

Governance of Agreement

Both parties acknowledge and agree that his agreement shall be constructed under the law of Alabama, the Local Provider consents to Alabama jurisdiction over any dispute arising under this agreement and venue of same shall lie in Mobile County, Alabama.

Patricia Vanderpool, LPC, CEAP, SAP

Affiliate Provider Signature

Date Signed

Date Signed

Date Mailed

EAP Lifestyle Management, LLC
Summary of Professional Background

EAP Lifestyle Management, LLC, in order to guarantee excellence in service necessitates your feedback to the questions below. We ask that you expound on the items to which you answer “yes” with written commentary, including an account of factors relevant to each respective item.

	Yes	No
a) Has your professional license/certification ever been denied, revoked, suspended or limited?		
b) Is there any action pending to revoke, suspend or limit your professional license/certification?		
c) Have you ever been denied professional liability insurance or has your insurance ever been canceled or denied renewal?		
d) Have any certifications, such as the Certified Employee Assistance Professional (CEAP) certification, even been revoked, suspended or limited?		
e) Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those functions without a direct threat to the health and safety of others?		
f) Is there any legal action pending related to your practice?		
g) Have you ever been the suspect of disciplinary proceedings by any professional association or organization (i.e. state licensing board, county, state or national professional society, hospital, medical or clinical staff)?		
h) Do you currently use illegal drugs or abuse drugs or alcohol?		
i) Do you have a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential function of a practitioner in your area of practice?		
j) Have you ever been convicted of a felony or involved in charges related to moral or ethical turpitude?		
k) Have you ever been named as a defendant in a criminal proceeding?		
l) Have you had any malpractice claims during the past five (5) years?		
m) Have you ever been a defendant in any lawsuit involving your practice where there has been a reward or payment of \$25,000 or more?		

Signature

Date

Printed name/title/credentials

Certification and Representation

Provider Name: _____ Group Name: _____

City/State: _____
(Please Print)

The undersigned acknowledges its support and compliance with an equal opportunity policy, and acknowledges that it conducts its business in a non-discriminatory fashion.

Signature: _____ Date: _____

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For our recordkeeping purposes, check all that apply to your company:

- | | |
|---|--|
| <input type="checkbox"/> White female is (are) over 50% owner(s) | |
| <input type="checkbox"/> Women is (are) over 50% owner(s) | |
| <input type="checkbox"/> Black/African American female is (are) over 50% owner(s) | <input type="checkbox"/> Asian Pacifica American male is (are) over 50% owner(s) |
| <input type="checkbox"/> Black/African American male is (are) over 50% owner(s) | <input type="checkbox"/> Asian Indian American female is (are) over 50% owner(s) |
| <input type="checkbox"/> Hispanic American female is (are) over 50% owner(s) | <input type="checkbox"/> Asian Indian American male is (are) over 50% owner(s) |
| <input type="checkbox"/> Hispanic American male is (are) over 50% owner(s) | <input type="checkbox"/> Disabled veteran is (are) over 50% owner(s) |
| <input type="checkbox"/> Native American female is (are) over 50% owner(s) | <input type="checkbox"/> Disabled persons is (are) over 50% owner(s) |
| <input type="checkbox"/> Native American male is (are) over 50% owner(s) | <input type="checkbox"/> Small business |
| <input type="checkbox"/> Asian Pacific American female is (are) over 50% owner(s) | <input type="checkbox"/> Disadvantaged business |
| | <input type="checkbox"/> Not a minority |
| | <input type="checkbox"/> Other |