Freedom of Choice Affidavit

I _____, verify that I have been offered at least two (2) referral recommendations as part of my EAP consultation and that I have instead decided to seek ongoing assistance through my Aurora EAP counselor's practice.

My signature below also verifies my understanding that in electing to seek treatment with the counselor named below, I have agreed to use my insurance benefits or pay privately for services. Aurora EAP is no longer responsible for the services provided.

Further, I am aware that no further services provided by this provider are covered by Aurora EAP and that *I am solely responsible for determining if services are covered under my health plan and payment for any services provided.*

CLIENT
SIGNATURE:_____ DATE:_____

AFFILIATE
SIGNATURE:_____ DATE:_____