The Steven A. Cohen Military Family Clinic at Centerstone

Clinic Information and Orientation

Welcome!

Welcome to the Steven A. Cohen Military Family Clinic at Centerstone. We are glad you are here and honored that you have chosen to seek care with us. Please review the information below and feel free to ask any questions. We want your experience with us to be a positive one and for you to feel heard and attended to.

Hours: Monday – Thursday 8:00AM- 5:00PM., Friday 8 a.m. to 12 p.m. Extended hours are available upon request.

***Address*:** 775 Weatherly Drive Clarksville, TN 37043

About us

We provide quality, accessible, and comprehensive mental health care to veterans and their families regardless of ability to pay. Services are available to any person who has served in the U.S. Armed Forces, including the National Guard and Reserves, regardless of role or discharge status. We use time limited, evidenced-based practices provided by trained and credentialed staff who are bound by professional ethical standards. Veterans and their family members can receive services individually and as a family unit at the same place with the same treatment team. We encourage family involvement and help connect families to community resources and services, as necessary.

We are accredited by CARF International. If you have any feedback, you can contact CARF at feedback@carf.org or (866) 510-2273.

About your care

You are invited to be an active participant in the treatment-planning process. You and your therapist will formulate a treatment plan that incorporates evidence-based practices along with your individual strengths, needs, abilities, and preferences. Most of our clients are involved in therapy here for 3-4 months at a time. Therapy sessions are typically 50 minutes. Treatment may include individual, couples, family, or group therapy; case management services are also available. Referrals can be made for current clients if medication management is needed or desired.

Due to the time-limited nature of our clinic, we are unable to see clients for long-term, ongoing care. If you need longer-term care, we can assist in making referrals and helping you find the necessary care. Discharge from services will occur when you and your clinician agree that you have met most or all of your treatment goals or that your needs are better served elsewhere. As part of your transition, we will work together to identify the resources that best fit your needs moving forward.

We regularly ask clients to complete questionnaires for a variety of purposes, including to track symptoms, to assess progress in treatment, and to gain feedback on our functioning as a clinic so we can better serve our clients. We will ask you to complete these measures during treatment. Follow-up calls will be made at the following intervals: 1, 3, 6, & 12 months

Scheduling:

Please call our main line **(931) 221-3850 to** schedule, cancel or reschedule appointments. Our Office coordinator can connect you to a provider's direct line or you can contact providers directly; please note that direct calls may be routed to voice mail while staff members are occupied or out of the office. Our main email address is **cohen@centerstone.org** and will be checked frequently. Staff can also be reached directly via email, though know that our responses will be limited based on privacy laws.

After Hours Calls/Emergencies:

After hours calls to the main line are routed to an answering service managed by trained veteran peers. Reports regarding these calls are routed to the clinic the next day; please note for cancellations these may not be received by clinic staff for up to 24 hours after you call. For emergency/crisis situations, please call 911 or go to your local emergency room. You may also use the VA Veteran Crisis Line (1-800-273-8255) or the Crisis Intervention Hotline (1-800-681-7444).

Late policy

When possible, please notify us if you are running late. We will do our best to accommodate you. However, please know that if you are late by 15 minutes or more, we may need to reschedule your appointment.

Cancellation policy

Please notify us at least 24 hours in advance if you need to cancel an appointment; if outside of clinic hours, call or e-mail and provide a reason for the cancellation. If you miss or cancel 3 scheduled appointments without advance notice, your treatment may be discontinued. Ensuring commitment to care allows us to best serve you, fellow Veterans and family members.

Can I bring the following items into the clinic?

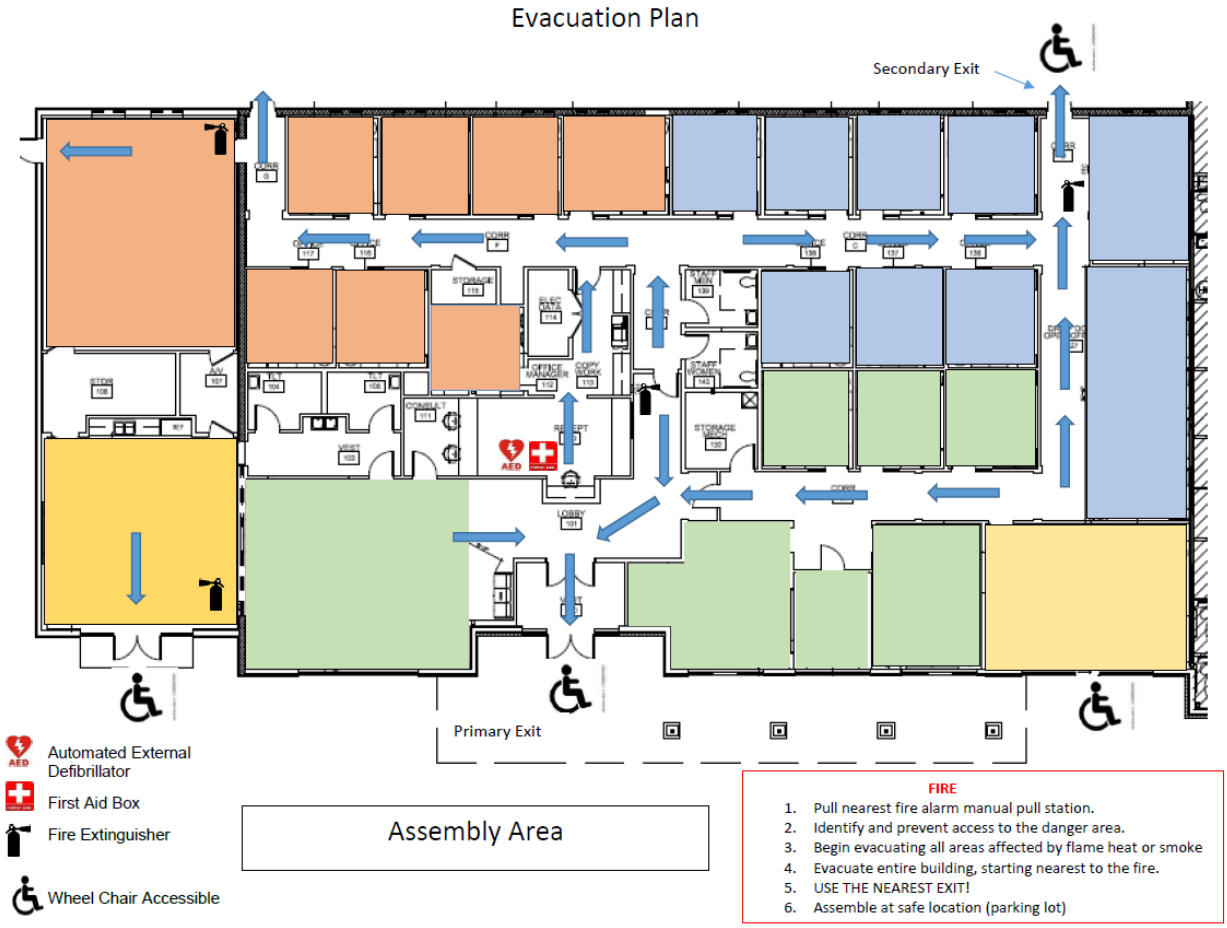
Illegal/Legal Drugs and Alcohol: The possession of illegal drugs, alcohol, or chemicals or inappropriate use of legal drugs or prescription medications is prohibited in the facility or on the premises. If you are asked to bring your medications, or if you have to take medication while you are at our office, it is important that you secure your medication at all times. Services will not be provided to individuals who are under the influence of substances at the time of their appointment, and we will take appropriate measures in an attempt to ensure everyone's safety.

Weapons: Centerstone seeks to provide a safe environment at all times. The possession or use of firearms, weapons or other items that pose a risk to other clients or staff is not permitted in the facility premises.

Tobacco: The Steven A. Cohen Military Family Clinic at Centerstone is a tobacco free facility. The use of tobacco and e-cigarettes is not allowed.

What do I do in case of emergency while at the clinic?

See map below for location of emergency exits, first aid kits, and fire extinguishers. Should you need to shelter-in-place, proceed to side hall way or one of the offices in the center of the buildings.



Commitment to Treatment Statement

I, _____, agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of counseling and treatment, including:

- Understanding that attending sessions is vital to my progress. Being that this clinic practices short term models, commitment to my appointments is the only way to maximize my success.
    a. If I need to cancel or reschedule my appointment, I need to do so 24 hours prior of my scheduled appointment.
    b. Failure to do this three times may result in being discharged from the program. After my second time and/or rescheduling multiple times, I will be required to speak with my clinician before getting a new appointment.
    c. Re-entry into services is based on a case by case basis discussed by the clinical team. If there is an active waiting list and it's agreed by the clinical team that you are appropriate for services again, you will be placed on it.
- If I am more than 15 minutes late for my appointment, I will be rescheduled, and it will be marked as a no-show.
- Being actively involved during sessions including; setting goals, voicing my opinions, thoughts, and feelings honestly and openly with my clinician.
- Completing homework, tasks, and other behavior experiments that were agreed upon during sessions.
- Taking my medications as prescribed by my physician. Or, if I want a medication change, dosage change, or want to discontinue any of my medications I will do this under the advisement and treatment of my physician.
- Trying out new behaviors and new ways of doing things.
- Implementing my crisis response plan when needed.
- Provide information about other treatments and treatment providers that may impact my treatment here. This may include medication records, other diagnoses, and other counseling or case management services.
- I realize that no matter what my current circumstances, past experiences, and triggers are, I am ultimately responsible for my behaviors.

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. I understand that as hard as my clinician will work, they can't work harder than me. If I feel that treatment is not working, I agree to discuss it with my clinician and attempt to come to a mutual understanding as to what the problem is and to identify any potential solutions. I understand that my clinician's primary motivation is to help me achieve my wellness goals, and it will not upset them or hurt their feelings to help me find an alternative treatment provider if doing so is what I desire and/ or is in my best interest.

In short, **I agree to make a commitment on the journey "Back to Better."**

Client Signature: _____ Date: _____

Centerstone Consent to Treat

I have read, or have had read to me, an orientation to services which includes the issues and points reflected in The Steven A. Cohen Military Family Clinic at Centerstone Client Resource Guide. I have discussed those points I did not understand, and have had my questions (if any) fully answered. Staff has told me about the safety features of this office, including the location of emergency exits and fire extinguishers, and that a first aid kit is available if needed. I agree to act according to the points covered in the Client Resource Guide. I do hereby seek and consent to take part in the treatment provided by The Steven A. Cohen Military Family Clinic at Centerstone. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that after my treatment with The Steven A. Cohen Military Family Clinic at Centerstone begins, I have the right to refuse or express choice regarding the services I receive, for any reason. However, I will make every effort to discuss my concerns about my progress with my treating professional before ending therapy. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24-hours before the time of the appointment. If I do not cancel or do not show up, I may be charged for that appointment.

I am aware that an agent of my insurance company, or other third-party payer, may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. This information may be shared until all claims are processed for this treatment episode. I also request payment be made to The Steven A. Cohen Military Family Clinic at Centerstone.

My signature below shows that I have been provided an orientation to services, and a copy of my rights and responsibilities either via the Centerstone Client Resource Guide or the annual Client Rights Update. It also shows that I understand and agree with the above statements.

_____ _____ _____

Printed Client Name Client ID Number Date of Birth

_____

Signature of Client Date

_____

Guardian/Conservator Signature Date

For purposes of consent, unless declared incompetent, individuals ages 16 and over have the legal right to consent to mental health treatment.

Centerstone Telemental Health Service Informed Consent

Telemental health is a service that is provided at many clinic-based sites within Centerstone. The goal around use of this technology is to improve access and reduce barriers to services for our clients. This involves the use of audio-video technology by a Centerstone provider to deliver a service to a client either in the community. With my permission, this connection will allow me, my family members, and other mental health providers to meet over the videoconferencing system to discuss my ongoing care, treatment and follow-up.

My participation in telehealth services is voluntary. If I decide that I do not wish to participate in telehealth services I may discontinue at any time and face-to-face services will be arranged for me.

My privacy and confidentiality will be protected at all times. Only the staff involved in my treatment, or those persons who have my permission, will see me over the videoconferencing equipment. If my well-being and/or safety is in question, my provider may contact my identified emergency contact to check on me.

By signing below, I verify that telemental health services have been explained to me and I voluntarily agree to participate. I understand that all information about me will remain confidential and will be used only for treatment purposes.

_____

Client/ Guardian Signature Date

Telemental Health Interest Questionnaire

1. If it is offered, would you be interested in receiving mental health services from our clinic to your home via videoconferencing technologies?

   _____ YES (If YES, continue) _____ NO (**IF NO, STOP HERE**)

2. Do you have a personal computer, tablet, laptop, or mobile device?

   _____ YES _____ NO

3. At your house, do you have a broadband wired, or wireless internet connection (3G or 4G/LTE)?

   _____ YES _____ NO

4. Do you have speakers and a microphone (either built-in, USB plug-in, or Bluetooth wireless)?

   _____ YES _____ NO

5. Do you have a webcam/HD webcam (either built-in or USB plug in)?

   _____ YES _____ NO

6. Do you have a space in which you can participate in session with privacy?

   _____ YES _____NO

Centerstone Affiliated Covered Entity

Notice of Privacy Practices

CLIENT'S ACKNOWLEDGEMENT

By indicating below, Client hereby acknowledges that he/she has received a copy of our Notice of Privacy Practices.

_____

Client Signature

_____ _____

Print Name of Client Date

If you are signing on behalf of a Client, please indicate your relationship to the Client or capacity to serve as Client's Representative.

_____

Representative Signature

_____

Relationship

_____

Date

Effective Date of the Notice: September 20, 2013

Financial Attestation

I, _____, declare that

(Patient Name)

_____ I understand my insurance will be billed. I will be responsible for my copay (if any is required) at the time of service from The Steven A. Cohen Military Family Clinic at (clinics name).

_____ I am not covered by any insurance policy, through myself or any source at this time of treatment. Should any insurance become effective during my treatment I will notify the Clinic. I am requesting financial assistance from the Cohen Financial Assistance Fund to cover my treatment.

Whether or not I have insurance, I understand that payment will not be a barrier to receiving care at the Clinic and that financial assistance is available from the Cohen Financial Assistance Fund, if necessary. I further understand that funding from the Cohen Financial Assistance Fund is excess to all other insurance available.

_____ _____

(Patient or Parent/Guardian signature if insured is a minor) (Date)

_____ _____

(Clinic Staff Witness) (Date)

FRAUD WARNING:

ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES

CENTERSTONE

AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____ **DOB** _____ **Social Security #** _____

Client ID# _____

I understand that I have a right to a copy of this authorization after I sign it.

YES	NO	
___	___	1. Medical History, examinations, laboratory tests and treatment reports.
___	___	2. Psychological test/psychiatric evaluation/neurological workup.
___	___	3. Social history, including family, education, employment, arrest and drug use information.
___	___	4. Summary of previous mental health treatment.
___	___	5. Periodic reports of current treatment progress including attendance, participation and urine surveillance results.
___	___	6. Other (Specify) _____

Treatment Dates to Release: _____

From/To: Steven A. Cohen Military Family Clinic 775 Weatherly Dr. Clarksville, TN 37043

(Name & Address of Centerstone site)

From/To: _____

I understand that this information will be used for the following specific purposes: (Check Yes or No)

YES	NO	
___	___	1. To develop a diagnosis, treatment and rehabilitation plan
___	___	2. To coordinate medical, psychological and social rehabilitative process.
___	___	3. To determine present and future eligibility for probation, parole, bail bond, pre-trial release or other diversion process within the criminal justice system.
___	___	4. To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment.)
___	___	5. Other (Specify if yes is checked)_____

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Centerstone is not responsible for any alterations made on its medical record copies, which have been released to any party.

I understand that I have a right to a copy of this authorization after I sign it.

I understand that Centerstone will not condition any provision of treatment on my signing this authorization.

This authorization automatically expires 1 year after the date that I sign it. I understand that this authorization may be revoked at any time with my written statement.

This authorization for **Release of Information** is given freely, voluntarily and without coercion.

_____ _____

Signature of Client **Date** **Witness** **Date**

Signature of person authorized to sign in lieu of client: _____

Guardian / Conservator / Personal Representative **Date**

Revised: April 18, 2017

Pain Questionnaire

In the past 3 months, have you been experiencing pain that interferes with your normal activities on **more than half the days each month?** Yes ❑ No ❑

If yes, please rate your pain by circling the number that best describes your pain in the last 24 hours:

1									10
No pain	2	3	4	5	6	7	8	9	As bad as you can imagine

How much has your pain interfered with your normal activities (including work outside and inside the house)?

1									10
No interference	2	3	4	5	6	7	8	9	Complete interference

Do you need additional help with your pain? Yes ❑ No ❑

Health Questionnaire

Q-LES-Q-SF

Taking everything into consideration, **during the past week**, how satisfied have you been with your…

	Very Poor	Poor	Fair	Good	Very Good
1. physical health	1	2	3	4	5
2. mood	1	2	3	4	5
3. work	1	2	3	4	5
4. household activities	1	2	3	4	5
5. social relationships	1	2	3	4	5
6. family relationships	1	2	3	4	5
7. leisure time activities	1	2	3	4	5
8. ability to function in daily life	1	2	3	4	5
9. sexual drive, interest, and/or performance*	1	2	3	4	5
10. economic status	1	2	3	4	5
11. living/housing situation*	1	2	3	4	5
12. ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
13. your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
14. overall sense of well being	1	2	3	4	5
15. medication (if not taking any, check here ❑ and leave item blank)	1	2	3	4	5
16. How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction. *(For example, if your satisfaction is poor for your housing situation, underline housing.)*

Childhood Experiences Questionnaire

ACE

While you were growing up, during your first 18 years of life:	**Yes**	**No**
1. Did a parent or other adult in the household **often** … Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at you? **or** **Ever** hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you **ever**… Touch or fondle you or have you touch their body in a sexual way? **or** Try to or actually have oral, anal, or vaginal sex with you?		
4. Did you **often** feel that … No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you **often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were your parents **ever** separated or divorced?		
7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **or** **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **or** **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
9. Was a household member depressed or mentally ill or did a household member attempt suicide?		
10. Did a household member go to prison?		

Relationship Questionnaire

RDAS

Are you currently in a relationship? Yes ❑ No ❑ (If NO, do not complete the rest of this questionnaire.)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always agree	Almost always agree	Occasionally agree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper behavior)	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0

	All of the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
8. How often do you and your partner quarrel?	0	1	2	3	4	5
9. Do you ever regret that you married (or live together)?	0	1	2	3	4	5
10. How often do you and your partner "get on each other's nerves"?	0	1	2	3	4	5

	Every day	Almost every day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	0	1	2	3	4	5
13. Work together on a project	0	1	2	3	4	5
14. Calmly discuss something	0	1	2	3	4	5