



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 a.m. to 5 p.m., Friday 8 a.m. to 12 p.m., extended hours are available based on clinician.

### **Clinic Locations and Contact Information:**

775 Weatherly Drive, Suite A, Clarksville, TN 37043

Office: (931) 221 – 3850

Email: [cohen@centerstone.org](mailto:cohen@centerstone.org)

7011 A. C. Skinner Parkway, Jacksonville, FL 32256

Office: (904) 431 – 3500

Email: [cohenfl@centerstone.org](mailto:cohenfl@centerstone.org)

1960 Kimball Avenue, Manhattan, KS 66502

Office: (785) 370 – 6400

Email: [cohenks@centerstone.org](mailto:cohenks@centerstone.org)

3505 Village Drive, Fayetteville, NC 28304

Office: (910) 500 - 1800

Email: [cohennc@centerstone.org](mailto:cohennc@centerstone.org)

345 W. Memorial Drive., Hinesville, GA 31313

Office: (912) 456 - 2010

Email: [cohenga@centerstone.org](mailto:cohenga@centerstone.org)

### **About us**

We provide quality, accessible, and comprehensive mental health care to Post-9/11 veterans and their families regardless of ability to pay. Services are available to any person who is serving or 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](mailto:feedback@carf.org) or (866) 510-2273.

### **Code of Conduct**

Therapists and other clinical staff must always act as professionals. All Centerstone staff members agree to follow strict guidelines (called the Centerstone Code of Conduct) about how they interact with clients and families. According to the Centerstone Code of Conduct, as well as the code of ethics that guides each professional discipline (social work, psychology and medicine) all staff are required to behave in a professional manner. This means they cannot be involved in any other part in your life, socialize with you, either in person or through social media (Facebook, twitter, Instagram, snapchat) or have a romantic or business relationship with you. This is a way to protect the confidentiality and importance of the therapy relationship. If you would like a copy of the Code of Conduct, please tell us.



### **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. Additionally, a Client Experience Survey will be sent up to 1 month after discharge.

### **Special Needs**

Please let us know as soon as possible if you are in need of special services such as an interpreter, so that we can arrange this service for you.

### **Scheduling**

Please call our central line at (877) 463 –6505 for routing to your specific clinic and to schedule, cancel or reschedule appointments. Our office coordinator can connect you to a provider's direct line if they are available at the time of your call.

### **Telehealth**

Your services may include telehealth (phone/video) services, which let you to talk to your therapist, case manager using audio or video conferencing over your phone, tablet or computer. A trained member of the Centerstone team will explain the benefits and/or risks of telehealth services and the process for connecting through telehealth to you. You will be asked to consent prior to the use of telehealth services, and you have the right to discontinue telehealth services at any time. Consenting to telehealth means being aware of the importance of data ownership, storage, and your responsibility in the security, privacy, and safety of telehealth sessions in the location of your choosing. Some treatment programs may require face-to-face services, or your provider may determine that face-to-face treatment is the best option for you.

If telehealth services are provided, Centerstone uses technology that protects your privacy and asks that you do the same. Sessions will not be recorded or stored without your consent or knowledge. We would ask that you not record sessions without talking to your provider. We encourage you to be available for telehealth services in a safe and private location (making sure that no one can overhear your conversation), which may include the ability to turn off your video or mute sound if needed.





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***After Hours Calls/Emergencies:***

After hours calls to the main line are routed to an after-hours voicemail for each clinic. These voicemails will be reviewed the morning of the next business day. For emergency/crisis situations, please call 911 or go to your local emergency room or call the National Suicide Crisis Lifeline by calling or texting 988.

***Late policy:***

When possible, please notify us if you are running late. We will do our best to accommodate you, including encouraging the use of telehealth in order to attend your appointment on time. However, please know that if you are late by 15 minutes or more, we reserve the right to reschedule your appointment, and it will constitute a late cancel without proper advanced notice.

***Cancellation policy:***

Please notify us at least 24 hours (or one full business day) in advance if you need to cancel an appointment. If you miss or late-cancel 3 scheduled appointments, your treatment may be discontinued. Ensuring commitment to care allows us to best serve you.

***Can I bring the following items into the clinic?***

**Illegal 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 any substances (except medication as prescribed) at the time of their appointment, and we will take the appropriate measures

**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.



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## 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 (or one full business day) prior of my scheduled appointment.
  - b. If I miss or late-cancel 3 schedule appointments, I understand that I may be discharged from the agency. After my second late-cancel 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 may 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.
- Attending appointments while sober and not under the influence of any substances (exception: medication being used as prescribed).
- 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/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## CENTERSTONE CONSENT TO TREATMENT

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 any concerns about my progress with my treating professional prior to ending therapy.

Telehealth 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. I may be provided the opportunity to receive services through a HIPAA compliant two-way audio-video technology. I understand that my participation in telehealth services is voluntary. If I decide that I do not wish to participate in telehealth services, or this service is deemed inappropriate by myself or my provider at any time, I will be offered a different follow-up plan.

I understand that my appointment times are being reserved for me and that efficiency of scheduling often depends on keeping my appointment as scheduled. I know that I must call to cancel an appointment at least one business day before the time of the appointment.

My privacy and confidentiality will be protected at all times. 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 have access to a copy of my rights and responsibilities via the Cohen Clinic at Centerstone's Client Resource Guide and Statement of Client Rights. It also shows that I understand and agree with the above statements.

I, the undersigned, agree and consent to participate in the mental health services offered, which may include service by telehealth methods

**Artificial Intelligence Use Disclosure:**

Centerstone uses AI for administrative and supplementary support such as scheduling appointments, billing, managing client records, note-taking, and for quality improvement purposes. Decisions related to your health care will not be made without oversight from a licensed clinician. By consenting, you acknowledge and consent to the use of AI in this process. \*

Yes       No

**Guardian Statement**

I attest that I have the legal authority to provide consent on behalf of the client by signing as the Guardian/Conservator. For purposes of consent, unless declared incompetent, individuals ages 18 and older have the right to consent to mental health treatment with proof of their date of birth.

\_\_\_\_\_  
Signature of Client or TN clients ages 16 and older

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Power of Attorney

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Representative

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



## Authorization to Bill

The Steven A. Cohen Military Family Clinic at (clinic's name) works in affiliation with Cohen Veterans Network, Inc. (CVN) [a 501(c)(3) nonprofit organization] to help fill gaps in mental health care for post-9/11 veterans, service members, and family members. The Steven A. Cohen Military Family Clinic at (clinic's name) will bill a client's insurance and collect any fees not covered by the party responsible.

### Client Information:

Client Legal Name: \_\_\_\_\_

Client DOB: \_\_\_\_\_

Responsible Party Name (if different): \_\_\_\_\_

Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Relationship to Client (if under a different name): \_\_\_\_\_

### Authorization:

\_\_\_\_\_ **I have health insurance and authorize the Steven A. Cohen Military Family Clinic at (clinic's name) to submit claims for reimbursement from my insurance for any and all billable services provided and accept payments from insurances on the client's behalf.** I authorize the Cohen Clinic to release any information needed by my insurer to appropriately process claims submitted on my behalf. I further understand that I am responsible for any required payment (such as co-payments, co-insurance, and deductibles) not covered by insurance. I understand that co-payments are expected to be paid at the time of service or upon receipt of a billing statement. I agree to be billed for any remaining balances not paid by my health insurance. I understand it is my responsibility to notify the Cohen Clinic staff of my desire to relinquish this authorization, if there are any changes in my insurance, or if my financial situation changes during the course of my treatment.

\_\_\_\_\_ **I am not covered by any health insurance policy**, through myself or any source at this time of treatment. I understand that I am responsible for the total cost of my care. Should any insurance become effective during my treatment I will notify the Cohen Clinic staff.

#### 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.

103376823.3

Client (or Responsible Party) Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_



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### HEALTH INSURANCE INFORMATION

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Primary Health Insurance: \_\_\_\_\_

Policy/Benefit Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_

Policy/Benefit Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_



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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.

103376823.3

I certify that all information provided in this application is true and correct, and I understand that the clinic may request supporting documentation to verify income including, but not limited to W2s, Income taxes, recent pay stubs, etc. I understand that I must notify the Cohen Clinic staff if my coverage/financial circumstances change to verify continued eligibility.

Client (or Responsible Party) Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

Print Name:

Relationship to Client:

\_\_\_\_\_

\_\_\_\_\_

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**\*INTERNAL USE ONLY\***

Application reviewed by: \_\_\_\_\_

Client Approved as Recipient of Cohen Compensated Care Fund

Client Denied

Reason:

\_\_\_\_\_  
\_\_\_\_\_

Terms of Assistance:

CCC Fund will cover Co-payment, Co-insurance, and/or Deductible only

CCC Fund will cover the total cost of care

Funding will remain in effect for the duration of this Episode of Care (EOC) and any related booster sessions unless eligibility changes. Should the client need additional services under a new EOC, another Request for Assistance application must be submitted and considered for approval.

Staff Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

## Centerstone of Tennessee – Release of Information

Client Name: _____	Client ID: _____	DOB: _____
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**Common Exchange (identity of entity)**

- |  |  |
|--|--|
| <input type="checkbox"/> Parent            | <input type="checkbox"/> Spouse                |
| <input type="checkbox"/> Child             | <input type="checkbox"/> Sibling               |
| <input type="checkbox"/> Significant Other | <input type="checkbox"/> PCP                   |
| <input type="checkbox"/> Attorney          | <input type="checkbox"/> Entity (organization) |
| <input type="checkbox"/> Client            | <input type="checkbox"/> Other _____           |

**Entity Authorizations**

- Release of Information from Centerstone  
 Release of Information to Centerstone
- I authorize Information Exchange via**
- |                                      |                                       |                                  |
|--------------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Verbal      | <input type="checkbox"/> Written      | <input type="checkbox"/> Fax     |
| <input type="checkbox"/> Thumb Drive | <input type="checkbox"/> Secure Email | <input type="checkbox"/> Printed |

<b>Entity/Name:</b> Cohen Veterans Network, Inc.	
Street: 72 Cummings Point Road	
City: Stamford	State: CT Zip: 06902
Phone: 844-336-4226	Fax: _____
Email: _____	

**Information to be Released:**

- Activity History  
 Assessment (e.g. AIMS, CANS, ANSA, NOMS)  
 Billing Information  
 Care Plan  
 Discharge Summary  
 Facesheet  
 Genetic Testing  
 Lab Tests or other Test Results  
 Medication/Injection Log  
 Other \_\_\_\_\_  
 Physical Exam  
 Progress Notes  
 Psychiatric/Psychological Evaluation  
 School Records and Staff Collaboration

**Information to be Obtained:**

- Activity History  
 Alcohol or Drug Use Records  
 Assessment (e.g. AIMS, CANS, ANSA, NOMS)  
 Billing Information  
 Care Plan  
 Diagnosis  
 Discharge Summary  
 Facesheet  
 Genetic Testing  
 Laboratory and Other Test Results  
 Medication/Injection Log  
 Other \_\_\_\_\_  
 Physical Exam  
 Progress Notes  
 Psychiatric Evaluation/Psychological Evaluation

**Indicate Specific Information to Exclude from Authorization:**

- Drug/Alcohol Records  
 Genetic Testing Results  
 HIV/AIDS Records  
 Infectious Disease Records  
 Mental Health Records  
 N/A

**Purpose of Information:**

- |   |  |
|---|--|
| <input type="checkbox"/> Audit/3 <sup>rd</sup>                      | <input type="checkbox"/> Client Request                          |
| <input checked="" type="checkbox"/> Coordination of Treatment       | <input type="checkbox"/> Department of Corrections               |
| <input type="checkbox"/> Disability/SSA                             | <input type="checkbox"/> Legal Proceedings                       |
| <input checked="" type="checkbox"/> Obtaining Insurance Information | <input type="checkbox"/> Other (Specify if Yes is Checked) _____ |
| <input checked="" type="checkbox"/> Payment                         | <input type="checkbox"/> Social Services                         |
| <input type="checkbox"/> Probation                                  |  |
| <input type="checkbox"/> State Required Reporting                   |  |

**Treatment Dates to Release**

- All Treatment Dates  
 Date Range \_\_\_\_\_ to \_\_\_\_\_

**Date Released based on today's Date:** \_\_\_\_\_ **Date Release Expires (365 days unless otherwise specified) Date:** \_\_\_\_\_

**HIM Statutes**

I understand that my records are protected under state and federal confidentiality statutes and/or regulations, and that the information used or disclosed may be subject to redisclosure by the person(s) receiving it and no longer protected by the federal privacy regulations. I further understand that these records will not be disclosed by Centerstone without my written authorization unless otherwise allowed by state or federal statute, rule, or regulation. I understand the released information may include HIV/AIDS, STD/STI information. I authorize the use of a photocopied, faxed, or scanned presentation of this form as a valid original for the release or disclosure of the information described above. I further authorize Centerstone and its agents to utilize this authorization electronically. I understand that Centerstone is not responsible for any alterations made to Centerstone records that are released to any party. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Centerstone. I understand that I have a right to a copy of this authorization. I understand that I may revoke this authorization at any time in accordance with 45 CFR 164.508 and 42 CFR Part 2, except to the extent that Centerstone has already acted in reliance on this authorization. A revocation should be in writing and delivered to Health Information Department.

\*Sending your personal health information to an email address or fax is not a secure delivery method and may expose your health information to others. By choosing this delivery method, you release Centerstone from any liability involving a potential or actual breach of your health information that has been delivered upon your request to an email address or by fax.

Notice to Recipient of Client Records/Information: Information pursuant to this authorization has been disclosed to you from records which may be protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. The receiving organization/party is advised and should understand that some or all of the information provided pursuant to this release may not be re-released without further consent of the client/patient except as allowed by statute, rule, or regulation. The receiving organization/party will be solely responsible for any unauthorized disclosure or use. This authorization to disclose was developed to comply with the provisions regarding disclosures of medical and mental health records, alcohol and drug abuse records, and other information under: Centerstone Policies; 42 CFR Part 2; Tennessee statutes, regulations, and case law; and HIPAA.

**Authorized Signature Description**

- |  |  |                                 |
|--|--|---------------------------------|
| <input type="checkbox"/> Legal Guardian              | <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Child 16 years old or older | <input type="checkbox"/> Client            |                                 |

\_\_\_\_\_  
Signature of Authorized Person Date

\_\_\_\_\_  
Printed name of Authorized Person Date