



The Steven A. Cohen
Military Family Clinic
at Metrocare

Client/Guardian Name: _____ Date: _____

CLINIC INFORMATION AND ORIENTATION

Welcome!

Welcome to the Steven A. Cohen Military Family Clinic at Metrocare. 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.

Hours: Monday – Thursday 9 a.m. to 8 p.m., Friday 8 a.m. to 1 p.m.

Address: 16160 Midway Road, Suite 218 Addison, TX 75001

Phone: 469-680-3500 **Email:** MFC@MetrocareServices.org

Social Media (Facebook, Twitter & Instagram): @CohenMetrocare

About us

Initial _____

We provide accessible and comprehensive mental health care to post-9/11 veterans, veterans' family members, and active-duty family members regardless of insurance. 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 targeted, 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. In addition to in-person, we utilize telehealth to provide services anywhere in Texas.

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

Initial _____

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. Current clients may be seen by a staff psychiatrist for medication evaluation and management.

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 and after-hours information

Initial _____

Please call our main line (469) 680-3500 or email MFC@metrocareservices.org to schedule, cancel or reschedule appointments. After hours calls to the main line are routed to an answering service managed by trained veteran peers. 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).

Staff can be reached directly via email, though responses will be limited based on privacy laws.

Late policy

Initial _____

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

Cancellation policy

Initial _____

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?

Initial _____

Illegal Drugs and Alcohol: The use, consumption, or possession of illegal drugs or alcohol is expressly prohibited. 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.

Legal Drugs (including OTC drugs, vitamins, herbs) and Prescription Medication: If you choose to bring other legal drugs or prescription medications on site, please adhere to the following guidelines: All items must be sealed, properly labelled (where appropriate), kept with you at all times, and not given or sold to any other individuals.

Weapons: Metrocare is classified as a governmental agency, which means that Texas Open Carry laws apply. We may not prohibit you from bringing firearms or knives under these laws; however, we ask that you be respectful of the therapeutic environment in deciding whether/how to bring any weapons on-site. For more information, please ask clinic staff.

Tobacco: All Metrocare locations are tobacco-free.

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

Initial _____

See map on next page for location of emergency exits, first aid kits, and fire extinguishers. Should you need to shelter-in-place, proceed to the conference room (115).



 FIRE EXTINGUISHER

 FIRST AID KIT

FIRE

1. Pull nearest fire alarm manual pull station.
2. Identify and prevent access to the danger area.
3. Begin evacuating all areas affected by flame heat or smoke.
4. Evacuate entire building, starting nearest to the fire.
5. **USE THE NEAREST EXIT!**
6. Assemble at safe location (parking lot).

Thank you!



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Consent for Services for Minor Child/Adolescent

I, _____ parent/legal guardian of _____ hereby
 acknowledge the following:

- **In cases of divorce/separation, a copy of the decree or legal documents pertaining to custody and mental health treatment decision-making rights must be provided.**
- **Consent to Evaluation and Assessment.** I consent for an evaluation and assessment to help determine my child/adolescent’s treatment/service needs. I understand the importance of providing detailed and accurate information during my child/adolescent’s evaluation.
- **Consent to Treatment/Services.** I consent for treatment/services to be provided to my child/adolescent. The clinician will develop a treatment plan in coordination with myself and/or my child/adolescent based on my child/adolescent’s evaluation and stated goals. The treatment plan will be explained and agreed upon before proceeding with services. Any changes to the plan will be discussed as part of ongoing services. Options for available alternative treatments will also be reviewed. At any time, I can opt out of the treatment/services.
- **Contact for Research Study.** The Steven A. Cohen Military Family Clinic at Metrocare (“Cohen Clinic”) may partner with the Cohen Veterans Network, Inc. (“CVN”), and its parent agency, Metrocare Services, to conduct research studies for the purposes of advancing the field of military behavioral healthcare and other behavioral healthcare. You are invited to volunteer for any Metrocare-approved research study for which your child/adolescent may qualify. Additionally, your child’s/adolescent’s participation serves to advance and expand the types of future treatment and services options for you, your child/adolescent, and your and your child’s/adolescent’s peers. Please check the box below to indicate whether you would like to be contacted by Cohen Clinic to participate in Metrocare-approved research studies.

<input type="checkbox"/> YES. I want to be contacted by Cohen Clinic about participating in Metrocare-approved research studies.	<input type="checkbox"/> NO. I do not want to be contacted by Cohen Clinic about participating in Metrocare-approved research studies.
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I understand that I may withdraw my consent to be contacted for research study by submitting my request to be withdrawn in writing. Cohen Clinic staff are available to assist me in the withdrawal of consent if needed. Alternatively, if I decide I want to be contacted for research study, I may contact Cohen Clinic to notify them of my interest.

- **Authorization for Payment.** I do OR do not authorize Cohen Clinic to bill my child/adolescent’s insurance company for all charges incurred in connection with my child/adolescent’s diagnosis, care, and treatment, and other eligible, covered services. I authorize and consent Cohen Clinic to use and disclose my child/adolescent’s health information to the insurance company as needed to obtain payment from the insurance company.
- **Notice of Privacy Practices.** I acknowledge that I have received the Notice of Privacy Practices which describes the ways in which the Cohen Clinic may use and disclose my child/adolescent’s health information for its treatment, payment, healthcare operations, and other prescribed and permitted uses and disclosures.

- **Individual Rights and Responsibilities of Persons Served.** I acknowledge that I have received the Individual Rights and Responsibilities document that summarizes rights and responsibilities while my child/adolescent is undergoing services within the agency.
- **Notice Regarding Your Right to File a Complaint.** I acknowledge that I have received this notice which describes how to make a complaint to Metrocare and/or state agencies.
- **Telehealth.** My child/adolescent may be provided the opportunity to receive services through a HIPAA compliant two-way audio/video link. I understand the benefits of this are increased access to care and convenience. The possible risks are interruption/disconnection to the audio/video link, delay in treatment due to failure of equipment, need for internet connection that may fail, and the lack of access to all information that might be available in an in-person visit. If telehealth services are deemed inappropriate by the provider at any time, my child/adolescent will be offered a different follow-up plan. By consenting to telehealth, I approve email communication to receive links to measures as well as appointments.

Consent to text, email & video recording

Text Messages & Email

I _____ consent to receive the following information from Cohen Clinic by the method(s) indicated below (*check all that apply*):

- Appointment reminders from the Cohen Clinic
- Other communications by the Cohen Clinic that do not fall under the impermissible categories below

I authorize and consent to the Cohen Clinic to (*check all that apply*):

- Send **text message communications*** to me at: _____ cell phone carrier: _____
*I understand that if I reply to a text message, I may incur additional charges from my phone carrier
- Send **e-mail communications** to: _____

I understand that it is my responsibility to provide the Cohen Clinic with my most current telephone number and e-mail address.

The Cohen Clinic **does not permit** the use of text or e-mail communications for the following:

- Emergency or time-sensitive issues;
- Highly sensitive or confidential medical and/or personal information, including protected health information;
- A substitute for clinical services or encounters; and
- Requests for medical records or other documentation.

I understand that by authorizing e-mail and text message communications that there are certain privacy and security risks involved with there being no guarantee that my text messages and/or e-mail are private and/or secure.

However, understanding these risks, I consent to receive e-mail and text message communications specifically for what I have authorized above and what is acceptable by the Cohen Clinic. **I can make changes or revoke my consent to receive future text message and/or e-mail communications as authorized above at any time by informing the Cohen Clinic of my intent.**

Audio/Video Recording

I _____ consent to audio/video consent to audio-only (no video) do not consent to audio/videotaping for training and supervision purposes. The contents of these taped sessions are confidential and the information will not be shared outside the context of training and supervision. I understand that I can request that the video recorder be turned off at any time and that the tape or any portion thereof be erased. I may terminate this permission to videotape at any time. Videos will be stored digitally and destroyed after they have served their purpose.

Acknowledgment. I have been given the opportunity to read and ask questions about the information contained in this form. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than to provide services to my child/adolescent. I understand that I may withdraw this consent for services by submitting my request in writing at any time.

Signature of Parent or Legal Guardian

Date

Printed Name of Parent or Legal Guardian

Signature of Cohen Clinic Staff Giving Explanation

Printed Name of Cohen Clinic Staff Giving Explanation



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Notice Regarding Your Right to File a Complaint

INDIVIDUAL
RESPONSIBILITIES

The Right to File a Complaint

If you are unhappy or unsatisfied with any service or any staff member from Metrocare Services, you have the right to file a complaint.

If you feel that any of your rights have been violated, you may also file a complaint.

Filing a Complaint with Metrocare:

1. Contact Metrocare’s Client Rights Protection Office directly at **(214) 743-1296** and speak with someone about your complaint; or
2. Submit your complaint in writing by mail to the following address:

**Client Rights Protection Office
Metrocare Services
1345 River Bend Drive, Suite 200
Dallas, Texas 75247**

3. Ask a staff member if you need help submitting your complaint by telephone or in writing to the Client Rights Protection Office on your behalf.

Please be prepared to provide the following information when filing a complaint:

- Your name, date of birth and phone number
- Name and date of birth of the individual who receives services from Metrocare if not same person
- Details of your complaint

Complaints may be submitted anonymously. However, without knowing your identity or additional information the Client Rights Protection Office may not be able to assist you further.

Complaints are assessed within 24 hours and prioritized in the order that it was received and based on the nature of the complaints.

Review:

Once your complaint is submitted, the Client Rights Protection Office will:

- Review your complaint,
- Contact you for further information as needed, and
- Notify you about the steps taken or that will be taken to address or resolve your complaint.

If you do not hear from anyone at Metrocare within 5 business days after submitting your complaint, please contact the Client Rights Protection Office at (214) 743-1296 for further assistance.

Resolution:

You should receive a call from the Client Rights Protection Office or another appointed person regarding an available resolution or the steps that will be taken in regards to resolving your complaint within 5 business days from the date the complaint was received.

Complaints are generally resolved within 14 business days of the initiation of a review.

Appeals Process:

If, after speaking with someone from the Client Rights Protection Office, your concern has not been satisfactorily resolved, you may contact the following to file a complaint:

- Regarding Mental Health Services:
**Department of State Health Services (“DSHS”) of
Consumer Services and Rights Protection
Phone: 1-800-252-8154**
- Regarding Intellectual and Developmental Disabilities Services:
**Department of Aging & Disability Services (“DADS”) Office of Consumer Services and Rights Protection
Phone: 1-800-458-9858**
- Regarding Substance Abuse or Narcotic Treatment:
**Substance Abuse Facility Investigations (MC 1979)
Phone: 1-800-832-9623**
- Regarding any services you receive here as this is an ACHC accredited organization:
**Accreditation Commission for Health Care, Inc. (“ACHC”) Consumer Complaints Against ACHC Accredited Organizations
Phone: Toll Free at 1-855-937-2242 or
(919) 785-1214**

By signing below, I acknowledge that I have received this Notice Regarding My Right to File a Complaint on this date.

Signature of Individual/Legal Representative

Date

Printed Name of Individual

Reviewed by: _____
Staff Member Printed Name

Name (First, Last):	RU:	DOB:	MRN:
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Personal Information

Name of child: _____
Last *First* *M.I.*

Gender Identity*: Male Female Other/Non-conforming
 Transgender, identifies as Male Transgender, identifies as Female

Name of parent/guardian completing questionnaire: _____

Relationship to child: _____

Name of additional parent/ guardian: _____

Relationship to child: _____

What is your custodial relationship to this child? Joint Sole Other
 Medical Decision-Making Authority

If joint custody, does the other parent agree to this child's treatment? Yes No

If other, who has sole custody of this child? _____

Child's Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Parent/Guardian's Address (if different from the child's):

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Preferred Language: _____ Secondary Language: _____

SSN: _____ Birth Date: _____

Race/Ethnicity: (Circle all that apply)

American Indian/
Alaska Native

Asian/
South Asian

Black/
African American

Hispanic/
Latino

Native Hawaiian/
Pacific Islander

White/
Caucasian

Other: _____

Emergency Contact Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Military Background

Which family member served in the US Military? _____

Military discharge status: Honorable General Other than honorable Unknown

Is s/he currently enrolled in the VA for health care? Yes No Unknown

Does s/he have a disability rating through the VA? Yes No

If yes, what is their percentage? _____

Parent/Guardian Background Information

Marital Status: (Circle one)

Now married

Divorced

Separated

Widowed

Never married

Living with partner

Other: _____

Highest level of education completed: (Circle one)

Less than high school

High school

Associates degree

College degree

Post college degree

Other: _____

Current employment status

Full-time

Part-time

Unemployed

Do not work

Other: _____

Current Employer: _____

What is your annual household income? \$ _____

How much of your annual household income comes from subsidies (e.g., disability benefits/ social security/ TANF/ other support)? \$ _____

How much of your annual household income comes from wages? \$ _____

Who currently resides in the child's home?

Name	Age	Relationship to Child
_____	_____	_____

Are there any firearms in your home? Yes No

If yes, please provide more information (if they are locked, who has access, etc):

Medical History

Is your child up to date on immunizations? Yes No

Does your child have any chronic illnesses or current physical problems? Yes No

If yes, please note any current health needs: _____

Does your child utilize tobacco, alcohol, or other substances? Yes No

If yes, please note substances used: _____

Does your child have any medication allergies? Yes No

If yes, please note medications: _____

Does your child have a primary care physician? Yes No

If yes, please list name/phone: _____

Is your child taking any prescription or non-prescription medications, including those for mental health? (please include any supplements or homeopathy) Yes No

Current Medications:

	<u>Medication</u>	<u>Dosage</u>	<u>Taken as Prescribed?</u>	
			<u>Yes</u>	<u>No</u>
1.				
2.				
3.				
4.				

Do you/your child feel the medications are effective? Yes No

If NO, please explain: _____

Are you concerned about any side effects or adverse reactions? Yes No

If YES, please explain: _____

Past Medications: Please list any past medications and their efficacy

	<u>Medication</u>	<u>Efficacy</u>	
		<u>Yes</u>	<u>No</u>
1.			
2.			
3.			
4.			

In the past two weeks, were there any changes to your child's medication? Yes No

If YES, what were the changes? _____

Social & School Background

What school does your child attend?

_____ *Name of school*

_____ *Street Address*

_____ *City, State, and Zip Code*

What grade is your child in currently?

Has your child ever received any education accommodations services?

Yes

No

If yes, please explain: _____

Child's Name: _____ Date of Birth: _____

Filled out by: _____ Today's Date: _____

Pediatric Symptom Checklist 17 (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child: Never Sometimes Often

	Never	Sometimes	Often
◆ Fidgety, unable to sit still	0	1	2
■ Feels sad, unhappy	0	1	2
◆ Daydreams too much	0	1	2
● Refuses to share	0	1	2
● Does not understand other people's feelings	0	1	2
■ Feels hopeless	0	1	2
◆ Has trouble concentrating	0	1	2
● Fights with other children	0	1	2
■ Is down on him or her self	0	1	2
● Blames others for his or her troubles	0	1	2
■ Seems to have less fun	0	1	2
● Does not listen to rules	0	1	2
◆ Acts as if driven by a motor	0	1	2
● Teases others	0	1	2
■ Worries a lot	0	1	2
● Takes things that do not belong to him or her	0	1	2
◆ Distracted easily	0	1	2

Total	◆	_____	Total	●	_____	Total	■	_____	◆	+	●	+	■	_____
-------	---	-------	-------	---	-------	-------	---	-------	---	---	---	---	---	-------