POCS Mental Health

34841 Veterans Plaza
Wayne, MI 48184

Phone: 734-728-3446
Fax: 734-589-6994

Dear _____,

I'd like to take a moment to welcome you as a new and valued consumer at POCS Mental Health. Thank you for choosing us. We look forward to partnering with you to address all your mental health needs. In addition, we would like your feedback on your initial visit and subsequent visits. It is very important that we receive your feedback on how we are doing. Our mission is to provide outstanding customer service to our consumers. If you have any concerns, or feel that your needs are not being met, please call one of our Directors at the numbers listed below.

Welcome once again!

Sincerely, POCS Management and Staff

Trenise Robinson
313-292-7640 Ext:206

Donna Collett
313-292-7640 Ext:107

Professional Outreach Counseling Services, PC

POCS Mental Health, PC

Demographic Information

Consumer's Last Name:_____ First Name:_____

Consumer's DOB:_____ SS#_____ ☐ Female Male ☐

Consumer's Phone Number:_____

Consumer's Address:_____

City/State Zip Code

Emergency Contact _____ _____

Name/Relationship Phone Number

Consumer's Guardian ☐ Self (if other than self, please complete section below)

Guardian Name/relationship: _____

Guardian Address:_____

Guardian phone number:_____

Primary Care Physician:_____ Phone Number:_____

Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widow

How many times have you been married:_____

Are you Pregnant:_____ Number of pregnancies:_____ Number of children:_____

Ages of children:_____ How many live at home:_____

How is your relationship with your spouse/partner?_____

Are you a member of a religion/spiritual group?_____

Surgeries: Type_____ Date:_____ Type_____ Date_____

Type_____ Date:_____ Type_____ Date_____

Hospitalizations: ☐ Yes ☐ No

If yes, please explain (list dates):

Family History

How would you describe your relationship with your mother:_____

How would you describe your relationship with your father:_____

Were you raised with biological, adoptive or foster parents:_____

Parents marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Is there a family history of mental health conditions in your family? ☐ YES ☐ NO

If yes, please explain:_____

Is there a family history of substance abuse: ☐ YES ☐ NO

If yes, please explain:_____

Reason for Your Visit

_____

_____

_____

How long have you been feeling this way?_____

Current Symptoms (check all that apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Feelings of Guilt
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Libido Changes
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Risky Activity
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Other_____
☐ Sleep Changes	☐ Suspiciousness	☐ Crying Spells	
☐ Suicidal	☐ Homicidal		

Have you ever attempted to commit suicide? if yes, when:_____

Current Therapist Name(N/A if none):_____Phone Number:_____

Highest grade completed:_____

Have you ever served in the military? ☐ Yes ☐ No

Are you currently in the service: ☐ Yes ☐ No

Branch name:_____ Highest rank achieved:_____

_____

Medical History

Medication Allergies:_____ _____ _____ _____

Environmental Allergies:_____

Do you exercise? ☐ Yes ☐ No

If yes, How often?_____ Type of Exercise:_____

Current Medications (please include non prescription medication):

▪ _____	▪ _____	▪ _____
▪ _____	▪ _____	▪ _____
▪ _____	▪ _____	▪ _____
▪ _____	▪ _____	▪ _____
▪ _____	▪ _____	▪ _____

_____

Substance Abuse History

☐ Tobacco ☐ Marijuana ☐ Cocaine

How often:_____ How often:_____ How often:_____

☐ Alcohol ☐ Methamphetamines ☐ Tranquilizers

How often:_____ How often:_____ How often:_____

Substance Abuse History (continued)

☐ Ecstasy ☐ Methadone ☐ Other_____
How often:_____ How often:_____ How often:_____

☐ Pain Killers ☐ Stimulants
How often:_____ How often:_____

Have you been treated for drug/alcohol abuse? ☐ Yes ☐ No
If yes, when:_____ Did you complete program successfully: ☐ Yes ☐ No

Have you ever abused prescription drugs: ☐ Yes ☐ No
If yes, please provide name and how often:

_____

_____

Please provide any additional information regarding your health concerns

_____

_____

_____

_____

_____

_____

_____

_____

_____

Consumer/Guardian Signature:_____
Date:_____

Professional Outreach Counseling Services, PC,
POCS Mental Health, PC

34841 Veterans Plaza
Wayne, MI 48184

Phone: 313-292-7640
Fax: 313-292-9270

Treatment Consent and Notification of Rights Form

Name of Patient: _____ **Birthdate:** _____

Consent or Request for Services:

I give POCS permission to provide the following service(s): Psychiatric Evaluation, Telesite Evaluation, Medication Review and/or Therapy.

I understand my consent may be withdrawn by me in writing at anytime. If my consent is not withdrawn, it shall automatically terminate one year from the date I have provided consent in writing.

Notification of Recipient Rights:

I have been given a copy of "YOUR RIGHTS IN MENTAL HEALTH", and received a summary of my recipient rights (Recipient's Bill of Rights) which I fully understand. These documents have been read and discussed with me by staff.

Notification of Grievance and Appeal Rights:

I understand that I have the right to file a grievance or appeal if I am not satisfied with any aspect of my services. I have the right to a person-centered treatment plan & services. I further understand that I have a right to speak to the Grievance & Appeals Coordinator.

_____ _____

Client/Guardian Signature **Date**

Professional Outreach Counseling Services, PC
POCS-Mental Health, PC

34841 Veterans Plaza
Wyane, MI 48184

Phone: (313) 292-7640 POCS
Fax: (313) 292-9270 POCS
Phone: (734)728-3446 POCS MH
Fax: (734) 589-6994 POCS MH

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's Name:_____ Phone:_____

Address:_____

Social Security #(Last 4)_____ D/O/B:_____

I authorize Professional Outreach Counseling Services, to RELEASE my medical records to the following Physician/Organization:

Name:_____

Address:_____

Phone:_____ **Fax:**_____

I understand that this authorization will expire one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. Revocation will not apply to information that has already been released by this authorization or to my insurance company.

I understand that any disclosure of information carries with the potential for unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.

☐ By checking this box, I decline the disclosure of any information contained in my medical records.

_____ _____
Patient or Patient Representative's Signature Date

_____ _____
Representative's Name (Please Print) Relationship to Patient

POCS MENTAL HEALTH
&
POCS

34841 Veterans Plaza Wayne, MI 48184 Ph. 734-728-3446Fax 313-292-9270

Client name:_____ D.O.B.: _____

Medication Prescribing policy

It is the policy of POCS Mental Health and its Affiliates to let care givers know that because consumers are prescribed medications from this office, they are required to obtain guardian's permission. The guardian has the right to attend the session or may designate a proxy to attend. Because some consumers who have behavioral problems and may need to have their medications adjusted/changed on a regular basis, the guardian may sign the medication form annually with the understanding that medications may have to be adjusted. **Bullet 5** of the consent form indicates that medications may have to be changed or adjusted in the event of behavioral problems, psychosis, emergencies, or if the psychiatrist or clinician makes the determination that a medication adjustment or change is necessary. If a guardian wants to be informed every time a medication adjustment or change is made, then they must be present for every medication appointment with the client. The guardian does have the right, to attend every session in order to make his/her wishes known. It is the responsibility of staff or care givers to inform the guardian of medication appointments since the staff or care givers are the ones who call to make the appointment. In the event the guardian is not present for the session or chooses not to attend, and there is a need to make a medication change, it is the responsibility of the care giver to secure the consent from the guardian before passing the new medication.

_____
Print staff name

_____ _____
Staff signature Date

By signing this form I understand that I must inform the guardian before the new medication/adjusted dose is passed.

34841 Veterans Plaza Wayne, MI 48184
ph. 734.728 3446
Email: pocservices@yahoo.com

Medication Prescribing Policy

TO: All Clients

FROM: Office Manager: Trenise Robinson, Director of Operations

SUBJECT: Physical Examination Needed

Please note that because you are prescribed medications from this office, you are required to obtain a physical examination from your primary care physician and forward the results to the staff of POCS Mental Health starting January 1, 2019. Results forwarded should include but not limited to:-Liver functions, heart function, blood pressure levels, cholesterol levels, Levels of current medications, and any other relevant results. We will not continue to prescribe medications if the results from your physical are not returned to us. If you have any questions regarding this matter, please feel free to contact the office manager.

Client's name if other than signer

PROFESSIONAL OUTREACH COUNSELING SERVICES, PC

34841 Veterans Plaza
Wayne, MI 48184

Phone: 313-292-7640
Fax: 313-292-9270

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing are means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Professional Outreach Counseling, P.C. and POCS Mental Health, P.C.

FINANCIAL POLICY

Thank you for choosing POCS as your provider. We are committed to providing you with quality services. It is important to us that you understand our Financial Policy so that you will know what your financial obligation will be.

PLEASE NOTE: IF YOU HAVE ACTIVE MEDICAID INSURANCE YOU WILL NOT BE CHARGED FOR ANY SERVICES. THIS INCLUDES, BUT IS NOT LIMITED TO, MEDICATION REVIEWS, PSYCHIATRIC EVALUATIONS, ANNUAL EXAMS, THERAPY SESSIONS, PAPERWORK, MISSED APPOINTMENTS, OR ANY OTHER SERVICES.

Cancellations and No Shows: If you cannot attend your scheduled appointment, please call no less than 24 hours in advance to cancel or reschedule. If you do not call, you will be charged a no-show fee of $100. This does not apply to clients with ACTIVE MEDICAID.

I agree to notify POCS of changes in my insurance. If at any time, I do not do so, I agree to be responsible for any charges to my account that are not covered due to changes in my insurance. I understand and agree that I am responsible for any charges I incur that are not covered by insurance. If, for any reason, I receive services and my insurance does not reimburse the agency I will be responsible for paying the total amount due.

By providing my credit card information, I acknowledge that I have read the above statement and agree to these terms: **(NOTE: If you DO NOT have a credit card, please ask to see a manager about alternative arrangements.)**

Credit Card (~~No Debit Cards~~) Number:_____

Expiration Date:_____ CVV_____

Billing Name: _____

Full Billing Address Including Zip Code:_____

_____

Cardholders Phone Number:_____

Psychiatric Services. If your behavioral health treatment includes the services of a licensed psychiatrist, POCS may engage an independent psychiatrist to autonomously treat you. Any psychiatrist so engaged will be an independent contractor of POCS, and not a principal or member of POCS. The independent psychiatrist will charge POCS for his or her services provided to you, and then POCS will bill you or the appropriate reimbursing party for the services.

Commercial Insurance and Managed Care: We will bill most insurance carriers as a courtesy for you if proper information is provided to us. This courtesy does not relieve you of your responsibility for payment of services rendered. Any outstanding balances, co-pays, and deductibles are your responsibility, and will be expected to be paid at the time of service.

Preauthorization: If your insurance carrier requires prior authorization, we will attempt to obtain the proper authorization. Be aware that if no authorization can be obtained, or if your insurance company denies the authorization of service (Or if considered Out of Network), you will be responsible to pay the full fee at the time of service.

Medicare: Our office is a Medicare participating provider. Any co-insurance and deductibles will be due at time of service.

If you do not have insurance: Payment in full is expected at time of service.

Refunds: If an overpayment occurs, it will be refunded to you. However, before a refund is returned, it will be applied to any outstanding balances on your account.

Paperwork: If paperwork is requested to by completed by our staff, there is a $65 fee for the completion of the paperwork. Record request costs will be based on Michigan State Mandated Fees and must be paid in full at the time of the request.

Therapy: If I cancel two consecutive appointments without adequate reason being given, my file will be closed, and my therapist will write a termination report.

The undersigned agrees, whether he or she signs as guarantor or as client, that he or she is hereby individually obligated to pay the account for all services rendered in full.

I have read and agree to the above terms:

_____	_____	_____
Patient Name Printed	Patient (Guardian) Signature	Date

_____

Staff Witness

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ + ___ + ___ + ___

= Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○