SYNERGY COUNSELING

OF GREENWOOD

Your Path To A Better Life

NEW PATIENT INTAKE PACKET

For Office Use Only						
Patient's Name:					Intake Counselor:	
Patient's Date of Birth:	/ /				Assigned Counselor:	
Number of Sessions Covered:					Date of Assessment:	
HIPPA Signed:		Yes		No	Date of First Session:	
Medical Release Signed:		Yes		No	Date of Last Session:	

SYNERGY COUNSELING OF GREENWOOD, LLC

101 East Cambridge Avenue, Greenwood, SC 29646 · PO BOX 49895, Greenwood, SC 29649

Tel: (864) 223-2243 · Fax: (864) 223-3044

Email: admin@synergycounselinggreenwood.com · Website: synergycounselinggreenwood.com

PATIENT INFORMATION/DEMOGRAPHIC FORM

Name: ____ Preferred Name: __________________________________

Date of Birth: _________________ Social Security Number: _______________________ Gender: _________________

Marital Status: Single: ____ Married: ____ Divorced: ____ Widowed: ____ Other: ________________________

Employment Status (P/F Time): _________ Employer: _______________________ Education Level: _____________

Phone Number: ________________________ Email Address: ____

Alternate Phone Number: _______________________ Preferred Method of Contact: __________________________

Street Address: ____

City: ____ State: ____________ Zip Code: _______________

Primary Care Physician Name, Address, and Phone Number: ____

____

Emergency Contact: _______________________ Relationship: ______________ Phone Number: ________________

I acknowledge that the above information is correct to the best of my knowledge. I authorize Synergy Counseling of Greenwood permission to render counseling services to me.

___________________________________ Patient Name

____ Parent/Guardian Name *(if the patient is a minor child)*

___________________________________ Patient or Parent/Guardian Signature

____ Today's Date

How did you hear about us? *Doctor Referral: _____ Employer: _____ Family/Friend: _____ Paper Ad: _____*
Social Media: _____ Google: _____ Other: ____

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Medical Records Release Form - Out

I consent to and authorize Synergy Counseling of Greenwood to release copies of my medical records:

Patient Name: ______________________________________

Address: ____

Date of Birth: ____ **SSN:** ____

The information you may release subject to this signed release form is as follows: ***PLEASE INITIAL BY EACH ONE***

_____ Complete Encounter Records/Notes

_____ Appointment History

_____ Certificates of Completion

Records Requested From:

Name of Person or Facility: Synergy Counseling of Greenwood

Practice Address: 101 E. Cambridge Ave Greenwood, SC 29646

Phone Number: 864-223-2243 **Fax Number:** 864-223-3044

Email address: admin@synergycounselinggreenwood.com or synergycounselingmanagement@gmail.com

Disclose Records To:

Name of Person or Facility: ____

Practice Address: ____

Phone Number: ____ **Fax Number:** ____________________________________

Email Address: ____

The Purpose/Reason for This Release of Information is as Follows:

____

____

Patient Signature: ____

Today's Date: __________________

INSURANCE/PAYMENT INFORMATION AND FEES

Service Fees

Service	Fee
Intake Assessment/Evaluation – 60 minutes	$155.00
Individual Therapy Session – 60 minutes	$125.00
Family & Couples Initial Assessment/Evaluation – 90 minutes	$175.00
Family & Couples Therapy Session – 60 minutes	$125.00
Batterers Intervention 26 Week Group Sessions (CDV) – 90 minutes	$50.00 for Intake/Assessment $30.00 for Each Group Session
FMLA Paperwork	$45.00
Medical Records, per page	$1.00

- <u>Insurance's Accepted:</u>
  - First Choice by Select Health of South Carolina
  - Molina Healthcare of South Carolina
  - Traditional State Medicaid

- <u>Methods of Payment:</u>
  - Cash or Debit/Credit Card ONLY
  - A 3% processing fee is added to ALL card payments.
  - Payment MUST be collected BEFORE any counseling session is completed.

- <u>No Show Policy:</u>
  - Synergy Counseling of Greenwood charges a $30.00 fee for missed appointments. Appointments should be canceled with at least 24 hours' notice. If this is not done, you will be charged the $30.00 fee before you are put back on the schedule.

- <u>Victim's Assistance (SOVA):</u> Those referred by SOVA are not required to pay anything out-of-pocket while attending approved/covered sessions. SOVA clients are required to present insurance information and any remaining balance not covered by insurance will be paid by SOVA. Those referred by SOVA are required to complete the necessary paperwork with the county or city in which the crime occurred; if this is not done, SOVA will not cover costs for services.

- <u>The Department of Social Services (DSS), Upper Savannah Care Services (USCS), Meg's House, and the South Carolina Vocational Rehabilitation Department (SC VOC Rehab):</u> Those who are referred by SCDSS, USCS, Meg's House, or SC VOC Rehab, are not required to pay anything out-of-pocket while attending approved or covered sessions unless specifically stated otherwise.

I have read, understand, and agree with the above financial policy for payments of professional fees.

________________________________ ________________________________

Signature of Responsible Party Today's Date

DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT

Confidentiality: The information you share in psychotherapy with a counselor at Synergy Counseling of Greenwood is generally considered confidential by South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. Synergy Counseling of Greenwood is mandated by state and federal regulations --- through duties to warn

--- to breach confidentiality if one discovers: 1) you are threatening self-harm or suicide; 2) you are threatening to harm another or homicide; 3) a child has been or is being abused or neglected; 4) a vulnerable adult has been or is being abused or neglected; and/or 5) you have broken or intend to break a law or laws. Finally, if you wish your protected health information (denied by HIPAA) released to someone (e.g., an attorney, physician, Worker's Compensation, etc.), you must sign a specific Release of Information.

Ethics: Counselors at Synergy Counseling of Greenwood follow the Code of Ethics as outlined by the following organizations:

- The South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-educational Specialists
- The American Counseling Association
- The American Psychological Association

Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned. Informed Consent: You will be asked to sign the last page of this document. Your signature verifies you have been given this document and the HIPAA document; that you have read and understand these documents and that you consent to treatment. Further you need to be aware:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- Synergy Counseling clinicians are not physicians and cannot prescribe medications.
- Clinicians may need to consult with their physician, attorney, or other counselor.
- Clinicians are not available 24 hours a day.
- Synergy Counseling clinicians, whether fully licensed or provisionally licensed, are licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, South Carolina. Tel: (803) 896-4652. Mailing Address: PO Box 11329, Columbia, SC 29211-1329.

I acknowledge that I have received and read the Synergy Counseling Services Disclosure Statement and Consent for Treatment (version 04/03). I further acknowledge that I seek and consent to treatment with Synergy Counseling MHPs. My signature below confirms that I understand and accept all the information contained in the Synergy Counseling Services Disclosure Statement and Consent for Treatment (version 04/03).

______________________________ ______________

Signature of Client Today's Date:

If more than one individual (e.g., spouse or family member) is seeking therapy, please have each of the other persons sign below. Signatures below confirm that each person understands and accepts all the information contained in the Synergy Counseling Services Disclosure Statement and Consent for Treatment (version 04/03) and the HIPAA Client's Rights (version 04/03) and that each seeks and consents to treatment. We will provide additional copies of the Synergy Counseling Services Disclosure Statement and Consent for Treatment (version 04/03) and the HIPAA Client's Rights (version (04/03) upon request.

______________________________ ______________

Signature of Client #2 Today's Date:

______________________________ ______________

Signature of Client #3 Today's Date:

______________________________ ______________

Signature of Client #4 Today's Date:

______________________________ ______________

Signature of Client #5 Today's Date:

______________________________ ______________

Signature of Client #6 Today's Date:

______________________________ ______________

Signature of Client #7 Today's Date:

INFORMED CONSENT FOR TELEHEALTH SERVICES

Definition of Telehealth:

Telehealth involves the use of electronic communications to enable Synergy Counseling of Greenwood's mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

If it is determined by you, or your healthcare provider, that a telehealth visit does not work for you for any reason, alternative support options can be considered.

Please read the below consent for telehealth treatment:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Synergy Counseling of Greenwood utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my counselor believes I would be better served by face-to-face services, telehealth services will be discontinued and a "face-to-face" office visit will be scheduled as soon as possible. If my counselor is unable to schedule a "face-to-face" office visit within a reasonable amount of time, then I will be referred to a mental health professional associated with any form of psychotherapy, and despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor to operate the video equipment. The people mentioned above will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party. If I have previously granted this permission through a “face-to-face” office visit, that consent will also apply to telehealth services without additional consent being required.
9. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or an emergency, I should immediately call 9-1-1 or seek help from a hospital, emergency medical facility, or crisis-oriented healthcare facility in my immediate area.
10. All existing laws regarding access to your medical information and copies of medical records apply.
11. You agree not to record or share the content of your telehealth visit. You agree to conduct the visit in a private space without any other attendees present, or able to hear or see your visit unless an alternative arrangement is agreed to by you and your provider. If someone comes into the room during your visit, please pause your video and restart only after they have left.
12. I understand that different states have different regulations for the use of telehealth. In South Carolina, telehealth may only be conducted between certified office locations. I understand that, in Wisconsin, I am not able to connect from an alternative location for the provision of audio-/video-/computer-based psychotherapy services.

Payment for Telehealth Services

Synergy Counseling of Greenwood will bill insurance for telehealth services when these services have been determined to be covered by an individual’s insurance plan. If insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a pay discount may be available. Please visit our website for details regarding the pay discount option, located at https://synergycounselinggreenwood.com. A statement of service for submission to your insurance company will be provided at your request.

Patient Consent to the Use of Telehealth

I have read this document carefully, understand the risks and benefits related to the use of telehealth services, and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

______________________________	______________________________
Patient’s Name	*Parent/Guardian Name (if the patient is a minor child)*
______________________________	________________
Patient’s or Parent/Guardian Signature	*Today’s Date*

The following information is needed to best help you. Please clearly print your response to each question. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Who do you live with? (resides in the same household)

Name	Age	Relationship	Supportive (Y/N)

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

How can the Counseling Center be most helpful to you? Please tell us what you want to work on or change in counseling: (e.g. Goals for Counseling)

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life").*

Have you ever been given a mental health diagnosis in the past from a mental health professional?

☐ Yes ☐ No

If yes, as you understand it, what is/was that diagnosis? ____

How would you estimate the severity of the problem at this time? (Place "X" on the line below)

________ Mild ________ Moderate ________ Serious ________ Severe

What symptoms contributed to you coming in today? (Please check all that apply)

_____ overeating	_____ restless	_____ rapid heart rate
_____ compulsive behaviors	_____ taking drugs	_____ depressed mood
_____ sweating	_____ impulsive behaviors	_____ odd behavior/thoughts
_____ crying	_____ trembling or shaking	_____ fears/phobias
_____ recent weight gain	_____ difficulty concentrating	_____ shortness of breath
_____ anxiety	_____ recent weight loss	_____ low motivation
_____ muscle tension	_____ vomiting	_____ recent appetite changes
_____ aggressive behavior	_____ outbursts of temper	_____ distrust
_____ social withdrawal	_____ feelings of worthlessness	_____ nightmares
_____ jumpy	_____ family emotional problems	_____ stomach problems
_____ easily distracted	_____ chest pain	_____ sleeping too much
_____ decreased need for sleep	_____ fatigue	_____ difficulty falling asleep
_____ problems with school	_____ housing problems	_____ obsessions
_____ difficulty staying asleep	_____ pain	_____ drinking alcohol
_____ relationship problems	_____ experienced a traumatic event	_____ financial problems
_____ can’t turn my mind off	_____ other _________________	_____ other _________________
_____ other _________________	_____ other _________________	_____ other _________________

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with school, relationship ending, death, past trauma, etc.):

____

____

____

____

In the past, what has been helpful to you in dealing with this problem?

____

____

____

SECTION III: MEDICAL HISTORY

Date of your last physical exam: ______________________________

Please list any significant past or current health, medical, or psychiatric issues *(including anything resulting in hospitalizations).*

Dates	Problem & Treatment	Were you hospitalized? (Y/N)

Have you ever experienced: *(Please mark all that apply)*

____ Emotional Abuse ____ Physical Abuse ____ Sexual Abuse ____ Sexual Assault

Have you, or anyone else, ever been concerned that you may have an eating disorder? ____Yes ____ No

Have you ever had treatment by, or are you currently seeing, a psychiatrist, psychologist, therapist, or counselor? ____ Yes ____ No

(If yes please give the following info):

Problem	Where	Therapist	Dates	Helpful (Y/N)

SECTION IV: MEDICATIONS AND SUBSTANCES USED *If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs, and supplements.*

Medication	Dosage	Person Prescribing	Length of Use?	Helpful (Y/N)
___________________________	__________	___________________________	_______________	_____________
___________________________	__________	___________________________	_______________	_____________
___________________________	__________	___________________________	_______________	_____________
___________________________	__________	___________________________	_______________	_____________
___________________________	__________	___________________________	_______________	_____________
___________________________	__________	___________________________	_______________	_____________
___________________________	__________	___________________________	_______________	_____________

If applicable, the number of caffeinated beverages per day: coffee _ soda _____ espresso _____ tea _____

If applicable, the number of cigarettes smoked per day: ______________

If applicable, how often do you use marijuana per week? _____________

Consider a typical week during the past month. In the table below, please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor
4 oz. of wine Number of drinks
1 oz. of hard alcohol (regular shot glass)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Number of Drinks							
Number of Hours							

Think of the occasion that you drank the most in the past month.

How much did you drink? ___________________________

How many hours did you drink? _____________________

If applicable, other substances used: ____

Do you use alcohol or drugs to *(check all that apply)*:

_______Manage stress? _______To relax? _______To change your mood? _______For sleep?

How often do you gamble? *(please mark one response)*

_____Never _____Once a Year _____2 to 3 limes a Year _____Every Other Month

_____2 to 3 Times a Month _____Once a Month _____ More Than Once a Week _____Weekly

_____Every Other Day _____Every Day

SECTION V: FAMILY OF ORIGIN INFORMATION

	Age	Name	Occupation	Deceased (Y/N)
(M) Parent/Guardian	________	____________________________	_____________________	_______________
(F) Parent/Guardian	________	____________________________	_____________________	_______________
(M) Step-parent	________	____________________________	_____________________	_______________
(F) Step-parent	________	____________________________	_____________________	_______________
Siblings	________	____________________________	_____________________	_______________
	________	____________________________	_____________________	_______________
	________	____________________________	_____________________	_______________
	________	____________________________	_____________________	_______________

Use the back of the sheet if necessary, More on the reverse side (Y/N) _

If applicable:

	Age	Name	Living with you? *(Y/N/Part time)*	Deceased (Y/N)
Children	________	____________________________	_____________________	_______________
	________	____________________________	_____________________	_______________
	________	____________________________	_____________________	_______________

Use the back of the sheet if necessary, More on the reverse side (Y/N) _

Are your parents divorced? Yes ______ No ______

Have any members of your family had problems with:

Drugs ______ Alcohol ______ Depression ______ Anxiety ______ Diabetes ______ Epilepsy ______

Other Mental Illness _________

Problem	Who	Current (Y/N)	Past (Y/N)
____	_______________________	_______________	_______________
____	_______________________	_______________	_______________
____	_______________________	_______________	_______________
____	_______________________	_______________	_______________
____	_______________________	_______________	_______________

Use the back of the sheet if necessary, More on the reverse side (Y/N) _

Among your friends and family, whom do you count on for support? ___________________________________

If applicable, describe your relationship with your current partner *(indicate on the line below)*.

☐ Major Problems ☐ Minor problems ☐ Satisfactory ☐ Very satisfactory

How long have you been in the relationship? ____

Is there anything else we need to know to better assist you?