SYNERGY COUNSELING

OF GREENWOOD

Your Path To A Better Life

NEW PATIENT INTAKE PACKET

Please complete as accurately as possible.

For Office Use Only							
Patient's Name:						Intake Counselor:	
Patient's Date of Birth:	/ /					Assigned Counselor:	
Number 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
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Patient's Name: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Marital Status: Single ☐ Married: ☐ Divorced: ☐ Other: ☐

Employment Status: _____ Name of Employer: _____

Phone number to confirm appointments: _____ Other phone: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Family Doctors Name: _____

I will be paying today by: _____

I authorize payment of medical benefits to the physician or supplier for services render, and the release of any medical information necessary to process my claim.

_____ _____
Patient's Name Parent/Guardian Name *(if patient is a minor child)*

_____ _____
Patient's or Parent/Guardian Signature Today's Date

Patient agrees to pay for all services due in full at the time of series are provided by our office.

WE ONLY ACCEPT: Cash, Debit/Credit Cards *(there will be a 3% charge on card transactions)*

PATIENT FINANCIAL CLASS POLICIES:

You are required to present any and all forms of valid insurance cards at every visit and as needed throughout you care. In addition, we require notification for any changes in address, phone numbers, employment, or insurance information. WE CURRENT ONLY ACCEPT TRADITIONAL MEDICAID AND FIRST CHOICE/SELECT HEALTH INSURANCE. You may be liable to pay a portion of, or the full amount for, your session and any sessions in the future.

Victim's Assistance {SOVA) and USCS: Individuals who are referred by the Office of Victim's Assistance or USCS (Upper Savannah Care Services), are not required to pay anything out-of-pocket while attending approved or covered sessions. SOVA and USCS clients with insurance are still required to present accurate insurance information for filing. We are required to process insurance information before payment is considered by either SOVA or USCS. Individuals referred by the Office of Victims Assistance are required to complete the necessary paperwork with the county or city in which the crime occurred, if this is not done properly or completely, the patient will be responsible for the balance.

METHODS OF PAYMENT:

We accept the following methods of payment:

- Cash, Debit/Credit Cards. Payment Plans are also available for those who are credit worthy.

Accounts are considered delinquent after 45 days of nonpayment and assessed a 6% late fee.

If not paid according to the above terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, the patient is required to pay the full balance owed and any additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees. Once an account has been turned over to a collection agency, no further services will be available to the patient in this office.

The Patient is ultimately responsible for all fees for services. I have read, understand and agree to the above financial policy for payments of professional fees.

_____ _____

Signature of Responsible Party Today's Date

(bottom of page intentionally left blank)

DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT

Fees: *It is customary to pay for professional services at the time they are rendered.* The fee for individual, couple and family therapy is $125.00 per hour and $65.00 per half hour. The fee for an initial assessment is $155.00 and the fee for an initial assessment for family therapy is $175.00 for 90 minutes. Rates will vary for group and therapy contingent upon services rendered.

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 beak 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 your physician, attorney or other counselor.
- Clinicians **are not** available 24 hours a day.
- Appointments may be successfully canceled as late as 24 hours prior to the scheduled time. **If this is not done, you may be charged $30.00 for a missed appointment**.
- 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.

Disclosure Statement and Consent Form for Treatment with Synergy Counseling Clinicians:

I acknowledge that I have received and read the Synergy Counseling Services Disclosure Statement and Consent for Treatment (version 04/03) and the HIPAA Client's Rights (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) and the HIPAA Client's Rights (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:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request. All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form (electronic, paper or oral) is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your therapist's/counselor's Professional Disclosure Statement and Consent for Treatment.

Use or disclosure of the following protected health information does not require your consent or authorization:

1. Uses and disclosures required by law - like files subpoenaed by a judge
2. Uses and disclosures about victims of abuse, neglect or domestic violence - like the duties to warn explained in your therapist's/counselor's Disclosure Statement
3. Uses and disclosures for health and oversight activities - like correcting records or correcting records already disclosed
4. Uses and disclosures for judicial and administrative proceedings - like a case where you are claiming malpractice or breech of ethics
5. Uses and disclosures for law enforcement purposes - like when you claim mental health issues as a defense in a civil or criminal case
6. Uses and disclosures for research purposes - like using client information in research; always maintaining confidentiality
7. Uses and disclosures to avert a serious threat to health or safety - like calling Probate Court for a commitment hearing
8. Uses and disclosures for Worker's Compensation - like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim

Your Rights as a Counseling/Therapy Client under HIPAA:

- As a client, you have the right to see your counseling/therapy file. Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.
- As a client, you have the right to receive a copy of your counseling/therapy file. Psychotherapy notes are afforded special protection under the HIPAA regulations and are excluded from this right. You will be required to pay copying fees @ $0.20/page.
- As a client, you have the right to request amendments to your counseling/therapy file.
- As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay copying fees $0.20/page.
- As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes or treatment, payment and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your counseling or therapy, you will receive 1) and exact duplicate of these two pages and 2) your therapist's/counselor's Professional Disclosure Statement and Consent for Treatment --- both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read and understand both documents. This certificate will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights or the Professional Disclosure Statement and Consent for Treatment. Your counselor or therapist will be happy to explain these documents further.
Thank you!

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 the course of 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 that 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 at 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 in order to operate the video equipment. The above-mentioned people 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 in an emergency, I should immediately call 9-1-1 or seek help from a hospital, emergency medical facility, or crisis-oriented health care 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. In the event that 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 and 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 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

Today's Date: _____

Patient's Name: _____ Education Level: _____

Email (optional): _____ Preferred Method of Contact: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who do you live with? (resides in 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

Name and address of Physician: _____

_____

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 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, number of caffeinated beverages per day: coffee ____ soda ____ espresso ____ tea ____

If applicable, 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 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 back of sheet if necessary, More on reverse side (Y/N) _____

If applicable:

	Age	Name	Living with you? *(Y/N/Part time)*	Deceased (Y/N)
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

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

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

Are you: ☐ Single ☐ Dating ☐ Married/Partnered
☐ Divorced/Unpartnered ☐ Widowed/a surviving partner

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? Please ask for an extra sheet of paper or feel free to use the back if needed. _____