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

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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 Will Be Paying By: Insurance: _____ Private Pay: _____ Agency: _____

Insurance Company: _____ Policy Number: _____ Start Date: _____

I acknowledge that the above information is correct to the best of my knowledge. I authorize Synergy Counseling of Greenwood 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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CONSENT FOR TREATMENT OF A JUVENILE

Any minor under the age of 18 who is seen in our office must have his or her parent or legal guardian sign this consent for treatment form.

Please be advised: Generally, children under the age of 18 do not legally have a right to confidentiality from their parents/legal guardians. This means that parents have a legal right to their children's information. However, we want to stress that a very important part of what makes therapy work is when clients (in this case minors) know that the information they choose to share will be kept private. Therapy is often a safe place for minors to process things in their lives that are scary or uncomfortable to share with the adults who take care of them. If minors feel that they can expect a reasonable amount of privacy in therapy, they are much more likely to make progress. We ask that parents respect this and not ask minors questions about what happened in their therapy sessions, but rather let the minor bring it up if they choose to. It is also important that both you (the guardian) and the minor understand the limits of confidentiality. In the event that the child shares something during the course of therapy that is necessary for the guardian to know (such as a safety issue), we will let the minor know that is something we have to share and then inform the guardian about the issue. All legal limits of confidentiality apply.

I, _____, give consent for treatment for _____
(Parent/Guardian) (Minor)
To be seen for therapy at Synergy Counseling of Greenwood. I confirm that I have legal custody of this child and have the right to authorize treatment for this minor.

In the case that there is any type of alternative custody situation, Synergy Counseling of Greenwood requires that the client provide written documentation of the custody agreement. If a second adult is required to consent for this child's treatment, please do so below:

I, _____, give consent for treatment for _____
(Parent/Guardian) (Minor)
To be seen for therapy at Synergy Counseling of Greenwood. I confirm that I have legal custody of this child and have the right to authorize treatment for this minor.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Synergy Counseling Staff Signature Date

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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

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

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

- Methods of Payment:
  - 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.

- No Show Policy:
  - 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.

- Victim's Assistance (SOVA): 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.

- The Department of Social Services (DSS), Upper Savannah Care Services (USCS), Meg's House, and the South Carolina Vocational Rehabilitation Department (SC VOC Rehab): 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?