SYNERGY OF SPIRIT
COUNSELING & HYPNOSIS

Synergy New Client Packet

- Intake Form
- Consent Form
- Health Insurance Claim Form
- Card Payment Authorization Form
- Financial Hardship Agreement
- Telemental Health Informed Consent
- Covid 19 Liability Form

SYNERGY OF SPIRIT INTAKE FORM

Please provide the following information below. Make note: All information you provide here is protected as confidential information. Please fill out this form and submit this form **PRIOR** to your first session. It can be submitted via the client portal or handed in during your 1st session.

Name: _____

Full Name including Middle Initial

Name of parent/guardian (if under 18 years of age):

_____

Full name Include middle initial (if applicable)

Birth Date:_____ Age: _____ Gender: _____ Marital Status: Never Married

Please list any children/age:

_____

_____

Address: _____

Street and Number

City State Zip Code

Home Phone: _____ May we leave a message? Yes

Cell/Other Phone: _____ May we leave a message? Yes

E-mail: _____ May we email you? Yes

*Please note: Email correspondence is not considered to be a communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc,)? Yes

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? Yes

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? Yes

If yes, please list and provide dates:

_____

_____

GENERAL HEALTH ANDMENTAL HEALTH INFORMATION

1. How would you rate your current physical health? Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

_ 2. How would you rate your current sleeping habits Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in

_____

_____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? Yes

If yes, for approximately, how long: _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes

If yes, please describe

_____

_____

8. Do you drink alcohol more than once a week? Yes

9. How often do you engage in recreational drug use? Never

10. Are you currently in a romantic relationship? Yes

If yes, for how long? _____

On a scale from 1 -10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Choose	If yes, list family member
Alcohol/Substance Abuse	Yes	
Anxiety	Yes	
Depression	Yes	
Domestic Violence	Yes	
Eating Disorders	Yes	
Obesity	Yes	
Obsessive Compulsive Behavior	Yes	
Schizophrenia	Yes	
Suicide Attempts	Yes	

ADDITIONAL INFORMATION

1. Are you currently employed? Yes

If yes, what is your current employment situation:

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

Signature:_____ Date:_____

SYNERGY OF SPIRIT
COUNSELING & HYPNOSIS

Consent to Treat and Acknowledgment of Privacy Practices

_____ this day retains Regina A. Orsi-Hoholik to provide either clinical assessment, psychotherapy, or alternative healing methods.You must chose which type of service you are to retain, as they possess different ethical guidelines of practice. It is expressly understood that the client above will not be issued, any guarantee of cure or treatment effects, or number of sessions necessary. **Reiki and Hypnosis are out-of-pocket services**. We, the undersigned counselor, and client(s) have read, discussed together, and fully understand this agreement and stated policies. We agree to honor these policies, and we will respect one another's views, and differences in their outworking. The Client(s) enter(s) into this agreement voluntarily, with competency & understanding and knowledge of the contract/policies.

I understand that once an appointment is made; regardless of cancellation issue; assigned payment /session is expected to be made up, the week of the session. If the client /therapist is experiencing illness, inclement weather, or other impeding circumstances; a phone session can be provided, or a makeup session within the month. Payment can be paid by credit or debit card within the session week. This method of payment will stay on file in our confidential software. Once session is paid, credit is listed, and you have up to a month to make up session time. Co-pays must be paid, as per insurance policies. **All co-payments and missed session payments will be automatically withdrawn from your account within 1 week of your session unless and arrangement has been discussed with Synergy office staff.** If there is any financial hardships; please speak with this writer or biller to set up a payment arrangement.

_____client initials

Success using Counseling/Hypnosis/Reiki is dependent on many variables including attitude, motivation, cooperation and attendance of scheduled sessions by the client. Even though human behavior cannot be ethically guaranteed, this practice makes the following service guarantee for our educational services to the client. It is suggested that one use reinforcement mp3s, and refrain from caffeine or stimulants 3 to 5 hours prior to the hypnosis session.

I understand that Hypnosis is used for the purpose of behavioral modification and to improve the quality of one's life. The provider may suggest additional services of psychotherapy, NLP, spiritual counseling, or Reiki healing. These modalities of treatment may be required/recommended, in addition to hypnotic interventions.

Hypnosis/Reiki healing does not diagnose illness, disease, or any other physical or mental conditions. Clients that are receiving metaphysical services of Reiki/Spiritual Counseling/Hypnosis will not require any review of documentation. No clinical services can be provided under this guise, no insurance submittable, nor reimbursement. Holistic services are not admissible in court cases, No legal documentation can be provided for any disability cases, custody, divorce etc.

If you are obtaining clinical services for the purpose of a disability case/legal case /divorce/custody hearing; please preface this upon intake, as it is up to the discretion of the therapist to take your clinical case. If you are seeking services for this premise, and have not notified this clinician of your intention; this can be seen as a conflict of interest, and may delay pertinent data to your legal defense team, All legal cases require that all progress notes, regardless of the nature of material may be subpoenaed by the court system/ attorney office, Even with the statue of the privilege, specific documentation cannot be protected under your HIPPA rights.

I have read and understand all information provided. I take full responsibility for my treatment and follow up methods. I will provide referrals or vital information to inform the hypnotist/psychotherapist of any new information regarding my mental or physical status.

I grant permission for all Synergy of Spirit office staff to contact me for billing, pertinent legal information, EAP services, collaboration and coordination with psychiatrists, FMLA or disability cases, and all necessary documentation for the file. I would advise all personal information is not to be sent to me via any social media platform or through regular texting. OHMD is another form of confidential communication to your therapist.

_____client initials

I understand that this Counselor is a Mandated Reporter, and must legally report suspected child abuse, suicidal ideation, or homicidal ideation to the proper authorities. All information other then the above information remains confidential. **Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:**

Duty to Warn and Protect:
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults:
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances:
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship:
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers :(when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

If you are referring a family member, spouse, or any other affiliate; there should be no disclosure of information shared in sessions. If there is a conflict of interest, the therapist must choose the patient that requires clinical attention. This writer will provide a referral to a collaborating partner/clinician.

If you are receiving holistic services (Hypnosis /Reiki) for substance abuse, eating disorder, or transgender transition; you must be seen by a specialist in this scope of practice. You must sign a waiver to allow this writer to collaborate with services /treatment plan/ intervention. It should be noted that this writer can meet for LGBTQ+ services. This writer is currently under clinical supervision with Transgender Institute. If you are requiring a letter of recommendation or hormone replacement, sexual reassignment, and cosmetic procedures, this writer will be co-writing with the Transgender Institute. The Transgender Institute has its own separate fee for assessments.

If you are referring your child under the age of 18; please sign and give preference of what treatment you are allowing this clinician to provide. Please sign a disclosure so that this provider can collaborate with other doctors or psychiatrist, or school officials that treat or serve this child/adolescent. All under age clients will need to have parent present during Reiki or hypnosis sessions.

Signature _____ Date _____

_____ Date _____
Clinician/Psychotherapist: Regina A. Orsi-Hoholik, LCSW, MS, CHT

In case of emergency call_____ Phone Number _____

SYNERGY OF SPIRIT
COUNSELING & HYPNOSIS

Card Payment Authorization Form

Sign and complete this form to authorize Synergy of Spirit to make payments, as agreed on for your co-pay or holistic services, to your credit/debit card listed below. You agree to allow Synergy of Spirit to automatically withdraw all session co-pays, missed appointment fees and session cancellation fees from your credit/debit card within 1 week of your session. A missed session can be rescheduled within one month of the initial cancellation or the client will be charged for the missed session. Canceled appointments are charged as a regular session. Missed or canceled appointments for holistic services are $75.

By signing this form you give Synergy of Spirit permission to debit your account for the co-payments, missed appointments and canceled appointments. This does not provide authorization for any additional unrelated debits or credits to your account (without your permission). Thank you for your services.

I _____ authorize Synergy of Spirit Inc to charge my debit / credit card for therapy sessions, holistic services, missed appointments and canceled appointments.

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Account Type: Visa

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No.. Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

GNATURE OF PHYSICIAN OR SUPPLIER CLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

Printed on Recycled Paper

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SYNERGY OF SPIRIT
COUNSELING & HYPNOSIS

Financial Hardship Agreement

I, _____, understand that I am personally financially responsible for any and all costs for my medical expenses that incur either because my insurance only covers a portion of the cost or because I have no insurance at the time of service. However, at this time I have financial difficulty which is making hard for me to pay for part or all of the expenses I am responsible for because of the following:

Lowor fixed income – Annual Household Income $_____ with_____ total household members

☐ Without any or applicable insurance for treatment at this clinic

☐ With applicable insurance but not full coverage for this treatment

I request under this Financial Hardship Agreement for the following discount assistance based on my annual household income and total family members. I would not be able to afford the cost of living if I was forced to pay in full for this treatment. I request this discount for the time period of from _____ to _____.

Patient's Signature _____ **Date** _____

Patient will receive the following discount based on their annual income levels.

____ Minimum co-pay per office visit of _____

____ Discounted rate of _____% of the total charges

Provider's Signature _____ **Date** _____

SYNERGY OF SPIRIT
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Disclosure Form/Release of Information

I _____, authorize Regina A. Orsi- Hoholik CSW,MS,CHT employed by Synergy of Spirit, to disclose relevant clinical information for the purpose of treatment planning, and intervention. Only relevant information is to be shared in collaboration with any psychiatrist, physician, school official, or legal person involved in treating this client/patient.

I have the right to revoke this statement at any time. All information from that time will remain confidential.

_____ _____
Signature of Guardian/Patient: Date

_____ _____
Clinician: Date

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Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, Regina A. Orsi-Hoholik as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 914-643-5700 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

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Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____
Signature of client/parent/legal guardian Date

_____ _____
Signature of therapist Date

The information is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case. ***Nothing reported herein should be used as a substitute for the advice of competent counsel.***

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COVID-19 Liability Waiver

First Name _____ Last Name _____

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Synergy of Spirit Counseling & Hypnosis has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19. I further acknowledge that Synergy of Spirit Counseling & Hypnosis can not guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to staff and other clients and their families. I voluntarily seek services provided by Synergy of Spirit Counseling & Hypnosis and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

- I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
- I have not traveled internationally within the last 14 days.
- I have not traveled to a highly impacted area within the United States of America in the last 14 days.
- I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
- I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Synergy of Spirit Counseling & Hypnosis harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the salon, or that may otherwise arise in any way in connection with any services received from Synergy of Spirit Counseling & Hypnosis.

I understand that this release discharges Synergy of Spirit Counseling & Hypnosis from any liability or claim that I, my heirs, or any personal representatives may have against the practice with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Synergy of Spirit Counseling & Hypnosis. This liability waiver and release extends to the practice together with all owners, partners, and employees.

Signature: _____ Date _____