# Mary A. Donnelly, INC

**Mary A. Donnelly, MA, LMHC, LPC**
**2804 Del Prado Blvd S Suite 109**
**Cape Coral, FL 33904**
**(239) 989-9738 Phone**
**(866) 582-5875 Fax**

TODAY'S DATE: _____

PATIENT'S FULL NAME: _____DATE OF BIRTH:_____

SPOUSE OR PARENT NAME:_____DATE OF BIRTH:_____

ADDRESS:_____
STREET OR P O BOX

_____
CITY STATE ZIP

PATIENT TELEPHONE: HOME _____CELL_____WORK _____

PATIENT EMAIL:_____

SPOUSE OR PARENT TELEPHONE:_____

AGE: _____MARITAL STATUS_____SSN#: _____

EMPLOYER OR SCHOOL (IF STUDENT): _____

REFERRED BY:
_____PHONE:_____

PERSON TO CONTACT IN AN EMERGENCY:

_____
NAME RELATIONSHIP PHONE

## INSURANCE INFORMATION

INSURANCE COMPANY: _____NAME OF INSURED:_____

INSURED'S SSN#: _____INSURED'S D.O. B.: _____

INSURED'S POLICY #:_____INSURED'S GROUP #: _____

INSURED'S EMPLOYER: _____AMOUNT OF CO PAYS: _____

INSURED'S RELATIONSHIP TO CLIENT:_____

AUTHORIZATION #:_____

IF YOUR COUNSELING IS BEING PAID FOR THROUGH AN EMPLOYEE ASSISTANCE PROGRAM, PLEASE LIST AUTHORIZATION NUMBER AND HOW MANY SESSIONS ARE BEING AUTHORIZED.
EAP COMPANY AUTHORIZATION NUMBER # OF SESSIONS

_____

**To be completed by therapist:**
**Primary Diagnosis**_____ **Secondary Diagnosis**_____

## **TREATMENT AGREEMENT**:

**PLEASE INITIAL:**
CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. _____

I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO MARY DONNELLY, INC. WHILE MARY DONNELLY, INC WILL BILL MY INSURANCE COMPANY, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED IF MY INSURANCE COMPANY DOES NOT PAY. _____

IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY TO OBTAIN THE PROPER AUTHORIZATIONS. IF I FAIL TO DO THIS AND CHARGES ARE DENIED I WILL BE RESPONSIBLE FOR ALL CHARGES. _____

IF YOUR PORTION OF THE BILL IS NOT PAID WITHIN 90 DAYS FROM THE LAST DATE IT WAS INCURRED, A LETTER WILL BE SENT GIVING YOU 14 DAYS TO PAY YOUR ACCOUNT OR TO ARRANGE FOR A PAYMENT PLAN. IF YOU DO NOT RESPOND YOU WILL BE SENT TO COLLECTIONS. _____

ALL INDIVIDUAL THERAPY SESSIONS ARE 45 MINUTES, FAMILY SESSIONS ARE 50 MINUTES, IN LENGTH._____

A 1% INTEREST WILL BE ADDED TO YOUR PORTION OF THE BILL THAT REMAINS UNPAID AFTER 30 DAYS._____

FEES ARE $150.00 FOR THE INITIAL SESSION AND $125.00 FOR SESSIONS THEREAFTER. _____

YOU WILL BE CHARGED $35.00 FOR MISSING AN APPOINTMENT OR NOT GIVING AT LEAST 8 HOURS PRIOR NOTICE TO CANCELING AN APPOINTMENT. _____

I HAVE RECEIVED THE TREATMENT AGREEMENT AND DISCLOSURE STATEMENT I UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY INSURANCE COMPANY, IF NECESSARY, AND ANY CHARGES DENIED BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

**CLIENT SIGNATURE**: _____**DATE**: _____

**TO ENABLE MARY DONNELLY WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:**
PLEASE BE AWARE THAT FAX TRANSMISSIONS ARRIVE AT MARY DONNELLY, INC. CONFIDENTIALITY IS MAINTAINED WITH THESE RECORDS, AS WITH ALL RECORDS IN MY OFFICE.

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY VOICE MAIL. _____YES _____NO

EMAIL MAY BE USED TO COMMUNICATE WITH ME. _____YES _____NO

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS**:**
_____

_____

**HEALTH INFORMATION:**
LIST ALL CURRENT MEDICATIONS:
_____

_____

NAME OF YOUR PRIMARY PHYSICIAN: _____MAY WE CONTACT? _____

PHONE NUMBER: _____ WHEN WERE YOU LAST SEEN? _____

I **GIVE MY CONSENT** FOR MY THERAPIST AT **MARY DONNELLY, INC** TO RELEASE MY RECORD TO MY PRIMARY PHYSICIAN SO THAT THEY CAN DISCUSS MY TREATMENT:
SIGNED_____DATE_____

**I DO NOT GIVE MY CONSENT** FOR MY THERAPIST AT **MARY DONNELLY, INC** TO RELEASE MY RECORDS TO MY PRIMARY PHYSICIAN:
SIGNED_____DATE_____