NEW PATIENTS

******THESE FORMS MUST BE COMPLETELY FILLED OUT (AND SIGNED WHERE INDICATED). If you are seeing Dr. McDonnell OR Dr. Mingolelli, Please FAX it in advance of your appointment to: 781-735-0457. If you are seeing Anne Turley-Griffith, you can FAX to 781-735-0716 OR YOU CAN EMAIL IT TO THE PROVIDER YOU WILL BE SEEING:**
Dr. McDonnell: maryannmcdonnell@yahoo.com, Annmarie Mingolelli , NP amm178@msn.com,
Anne Turley, NP anne.turley.griffith@gmail.com

NAME:

DATE OF BIRTH:

ADDRESS:

CELL PHONE:

EMAIL:

PARENT OR GUARDIAN (IF MINOR) OR EMERGENCY CONTACT:

IF USING INSURANCE, PLEASE PROVIDE THE FOLLOWING INFORMATION:
NAME OF INSURANCE COMPANY:

ID NUMBER:
GROUP NUMBER:

NAME OF SUBSCRIBER TO INSURANCE:
RELATIONSHIP TO PATIENT:

SUBSCRIBER'S ADDRESS AND PHONE #:
SUBSCRIBER'S DATE OF BIRTH:

PLEASE BRING COPY OF INSURANCE CARD TO FIRST VISIT

IT IS IMPORTANT TO PROVIDE A HISTORY OF ANY MEDICATIONS THAT YOU HAVE TAKEN IN THE PAST, WHEN THEY WERE TAKEN, AND YOUR RESPONSE TO THEM. IF YOU PREFER TO PROVIDE MEDICAL RECORDS FROM A PREVIOUS PRESCRIBER, YOU CAN CALL THEM AND HAVE THEM FAX THE RECORDS OVER TO US AT 781-735-0457 **BEFORE** YOUR FIRST VISIT.

Medication	**Dates taken**	**Response** **Did it work?**	**Side Effects**	**Reason Stopped**

LIST OF CURRENT MEDICATIONS:

NAME OF MEDICATION	DOSE	TIMES TAKEN PER DAY	REASON FOR TAKING IT

MEDICAL HISTORY

PLEASE LIST ANY PAST OR CURRENT MEDICAL PROBLEMS: PLEASE CHECK YES OR NO

	YES	NO		YES	NO
CONCUSSION			ASTHMA		
TRAUMATIC BRAIN INJURY			HEART PROBLEMS		
SEIZURES			LUNG PROBLEMS		
BLOOD CLOTS			GLAUCOMA		
ABNORMAL BLEEDING			LIVER PROBLEMS		
STOMACH PROBLEMS			KIDNEY PROBLEMS		

ANY OTHER MEDICAL PROBLEMS? PLEASE DESCRIBE:

IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT? YES___ NO___

WHEN WAS YOUR LAST PHYSICAL?_____. Please contact your primary care doctor and have them fax a copy of your medical history, last physical and labs to 781-735-0457 prior to your appt.

WHEN WAS THE LAST TIME YOU HAD BLOOD DRAWN?
****If you have had neuropsychological testing done, please bring a copy with you to your visit or email prior to visit.**

FAMILY HISTORY OF PSYCHIATRIC DISORDERS:
FAMILY MEMBER DIAGNOSIS
MOTHER:
FATHER:
GRANDPARENTS:
SISTERS:
BROTHERS:
CHILDREN:
COUSINS:
AUNTS OR UNCLES:
OTHER RELATIVE:

Have you ever abused drugs or alcohol? Yes ___ No___
Has anyone ever been concerned about your alcohol use? Yes ___ No___
How often do you currently drink alcohol? _____ drinks per event, _____ times per week.
How often do you smoke marijuana? ____times per day, ____ times per week.
How often do you take other illicit drugs? ____times per day, ___ times per week.

Have you ever been abused or neglected? Yes____ No_____
Have you ever experienced a traumatic event that caused you nightmares and to avoid certain people or places? Yes ___ No___

Have you ever had suicidal thoughts or attempted suicide? Yes ___ No___
Have you ever had homicidal thoughts or violent behavior? Yes ___ No___

Have you ever been hospitalized for emotional or behavioral problems?
If so, please list:
Name of Hospital Dates of hospitalization Reason for hospitalization

Insurance and Payment Policies

For Blue cross blue shield patients: Co-payments must be made at the time of the visit by cash, check or credit card. A bill for services will be sent by our staff directly to your insurance company. We accept Blue Cross Blue Shield but if you have an out of state BCBS plan or medicare or medicaid in addition to BCBS, You will need to pay out of pocket for the visit and be reimbursed for the services. Please check with your insurance about coverage and deductibles so you will not be surprised by fees that they hold you responsible for. All patients are responsible for payment of services that are not covered by insurance.

****We have a waiting list for patients who are anxious to get in for an appointment as soon as possible. If appointments are canceled at least 24 hours in advance, we can fill that slot with someone on the waiting list.**

Cancellation Policy: All appointments must be cancelled 24 hours in advance in order to avoid being charged for the missed appointment. (Insurance companies do not cover missed visits). Due to the high number of no shows and last minute cancelations, we are now collecting credit or debit card information to keep on file. **Your credit card will be charged ONLY FOR MISSED VISITS/ LAST MINUTE CANCELATIONS AND FOR OVERDUE BALANCES > 90 DAYS.** You will have the option to use another method of payment should you choose. In the event of a missed appointment, that has not been canceled at least 24 hours in advance, your card will be charged for the cost of that appointment ($150 for follow up visits).

Credit or Debit card information:

Name on Credit or Debit Card:_____

Please circle: Master card Visa American Express Debit Card

Card number_____

3 DIGITS on back of card_____ **(4 DIGITS FOR AMERICAN EXPRESS on front of card)**_____

Expiration Date:_____**Zip code:** _____

I acknowledge that I have read this policy and that I am responsible for fees that are not covered by my insurance company.

Client Signature_____ **Date:**_____

****THIS PAGE MUST BE COMPLETELY FILLED OUT AND SIGNED PRIOR TO SEEING YOUR PROVIDER AT THE FIRST VISIT**

South Shore Psychiatric Services Medical Release of Information (page 1 0f 2)

475 School St. Suite 1, Marshfield MA 02050 Phone: 781-837-8833 Fax: 781-735-0457

Patient Name_____ DOB:_____

Address_____

Patient Telephone Contact: Day: _____ Evening_____

I, _____ do hereby authorize South Shore Psychiatry, Inc. to release health information including copies of my medical and mental health record of care received from South Shore Psychiatry, Inc. personnel to the following person(s) at the locations/facilities listed for the purposes described:

****Please include phone and fax number**

Name of Provider ***Facility Address Phone Fax #***

Please include primary care doctor, therapist and any other doctor you would like us to be able to speak with.

1._____

2._____

_____

Treatment dates:ALL DATES_____X__ PURPOSE OF REQUEST:

__X_COORDINATION OF CARE

__X_DISABILITY _X__INSURANCE _X__LEGAL

___OTHER, SPECIFY_____

I AUTHORIZE THE DISCLOSURE OF THE FOLLOWING INFORMATION, WHICH MAY BE INCLUDED IN MY RECORD.

YOU MUST INITIAL BELOW. (GENETIC TESTING, SEXUALLY TRANSMITTED DISEASES, HIV INFORMATION, AIDS OR AIDS RELATED CONDITIONS, ABORTION). ALCOHOL & DRUG ABUSE RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES 42 CFR PART 2. ***Patient or Guardian Initials _____

I AUTHORIZE THE DISCLOSURE OF THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD.

_X__ Complete record Other: Please explain:_____

I understand that:

- **The provider of information disclosed cannot guarantee that the recipient will not red-disclose my health information to a 3rd party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the recipient is prohibited under the federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality or Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).**
- **I may revoke this authorization in writing at any time, except the at the revocation will not have any effect on any action taken by the provider before the provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to South Shore Psychiatric Services, PC at 475 School St, Suite 1, Marshfield, MA 02050.**
- **Unless otherwise revoked, this authorization will expire automatically within one year unless you insert a preferred date of expiration here _____.**
- **That authorizing the disclosure of health information is voluntary. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.**

Patient's Signature_____Date_____

Parent or Legal Guardian Signature _____ _____Date_____
(if under 18 years of age)

If legal guardian, relationship to Patient _____

SOUTH SHORE PSYCHIATRIC SERVICES PC

Prescription Refill Policy

It is important to keep track of your prescriptions so that you do not run out of medications. At your visit, you will receive enough medication to last until your next scheduled visit. If you need to cancel, make sure to reschedule in a timely fashion so as not to run out of medication. In the event that you do run out, refill requests can be called in to 781-837-8833 or you can discuss with your provider if it is okay to email them with these or other requests. ALL PATIENTS MUST BE SEEN AT LEAST ONCE EVERY 3 MONTHS IN ORDER TO GET REFILLS.

1 week notice is required for all prescription refills. Refills are not processed on Fridays, Saturdays or Sundays.

*****Do not rely on pharmacy refill requests as they often fax the request to the wrong number and they are not received. You need to call the office or email your provider for refills directly.**

Payment

Payment is due at the time of the visit for copays and/or out of pocket expenses. Payment can be made by cash, check, credit or debit card and given directly to your provider at each visit.

Cancellations or Rescheduling of Appointments

We require 24-hour notice for cancellations or rescheduling an appointment. You will be charged for missed appointments or cancellations of less than 24 hours. We have a list of clients who are eager to get in for an appointment so we can fill the open spot if we receive notification in advance of the appointment.

Please call 781-837-8833 or text Jodi at 781-424-7157 to change or cancel an appointment.

EMERGENCIES ONLY

For true medical or psychiatric emergencies, you should go to the emergency room and have the ER doctor contact your provider.

Mary Ann McDonnell: 781-424-5782, Anne Turley-Griffith: 781-412-4063, Annmarie Mingoleli: 617-306-1406.

****These numbers should not be used unless it is a true psychiatric emergency! For non-emergency issues, you can call the main number 781-837-8833 and someone will get back to you. Messages are not always checked on the weekends. I have received a copy and agree to the office policies:**

Signature_____**Date**_____