Mary Ann McDonnell, PhD, RNMS,CNS, PMHNP
Phone: 781-837-8833 Fax: 781-735-0457
160 Old Derby St. Suite 457, Hingham, MA 02043 E-mail: maryannmcdonnell@yahoo.com

Parent Request for Psychiatric Evaluation

******THESE FORMS MUST BE COMPLETELY FILLED OUT (AND SIGNED WHERE INDICATED) PRIOR TO YOUR APPOINTMENT.**

Please FAX completed forms to_781-374-7552_ in advance of your appointment to the provider you will be seeing. If you do not have access to a fax machine, you can email your forms (but anything that goes over the internet is not HIPPA compliant).

Consent Statement: By submitting this form I attest that I have legal authority to consent to a psychiatric consultation regarding the above-named child.

Signature:_____ Date_____

Treatment Consultations: I understand that the information gathered for the consultation will be summarized in a report protected as a confidential medical record by the Health Insurance Portability and Accountability Act (HIPAA). Reports will only be forwarded to other providers in response to my signed written medical release of information, and only to those parties that I designate. I know I can read about HIPAA rights at the U.S. Department of Health and Human Services web site at www.hhs.gov/ocr/hipaa/.

Initials: _____

Security of information: all reasonable precautions will be taken to maintain the confidentiality of the information to be submitted on this form.

Patient or Authorized person's signature: I authorize SSPS to submit insurance claims on my behalf. I authorize the release of any medical or other information necessary to process my insurance claims.

Signature _____ Date_____

South Shore Psychiatric Services, PC. Medical Release of Information (Page 1 of 2)

Patient Name:

DOB:

Address:

Patient and Parent Telephone Contact: Day: Evening:
I, _____ do hereby authorize South Shore Psychiatric Services, PC to obtain health information and reports from providers below and to release health information including copies of my medical and mental health record of care received from South Shore Psychiatric Services, P.C. to :name of person(s), the locations/facilities listed for the purposes described.
****Please include phone and fax number. If you don't have this information, please contact your provider and provide it on this form prior to your appointment. If you would like a family member or your parents to be able to speak with your provider, you must include their name below as well.**
1._Pediatrician:__Name: Address:

_____

_____Phone:_____Fax:_____

2. Therapist: Name: Address:

_____

_____Phone:_____Fax:_____

3. Previous Prescriber/Other: Name: Address:

_____

_____Phone:_____ _Fax:_____

(Medical release Page 2 of 2)

Treatment Dates: All Dates: _X_. Purpose Of Request: _X_.Coordination Of Care:_X_
Disability:_X__Insurance: _X__Legal _X_. Other: Specify_____
I authorize the disclosure of my complete record and the following information, which may be included in my record. (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 and Parent/Guardian Initials _____.
I understand that the provider of information disclosed cannot guarantee that the recipient will not redisclose 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 that 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 160 Old Derby Street, Suite 457, Hingham MA 02043.

Unless otherwise revoked, this authorization will expire automatically within one year unless you insert a preferred date of expiration here_____.

I understand that authorizing the disclosure of health information is voluntary and that I do not need to sign this form to ensure treatment. However, SSPS strongly encourages that communication between our clinicians and your primary care physician be allowed in the event that any medical problems arise while being treated at SSPS.

Patient's Signature_____Date_____

Parent or Legal Guardian Signature _____ Date_____

(if under 18 years of age). If you are a legal guardian, what is your relationship to the Patient:_____

PATIENT FULL NAME:

DATE OF BIRTH:

ADDRESS:

PARENT CELL PHONE: PARENT 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:
*Many insurance companies use other companies such as CVS caremark, Express scripts, Optum RX, etc to pay for their medications. If you use one of these for prescriptions, please provide the name of the company and your ID number below so we can do any prior authorizations for medications that are prescribed.

_____

_____

PLEASE BRING A COPY OF ALL YOUR INSURANCE CARDS TO YOUR FIRST VISIT OR COPY BOTH SIDES AND INCLUDE IN FAX.

Patient's History			
Developmental Milestones			**Notes**
Crawling, walking	Normal	Delayed	
Toilet training	Normal	Delayed	
Speech and language	Normal	Delayed	
Self-care (dressing, bathing)	Normal	Delayed	
Social skills	Normal	Delayed	
Play	Normal	Delayed	
Self-control	Normal	Delayed	
Other (describe below)			
	Normal	Delayed	

Temperament: as a baby or young child, was he/she:

	YES	**NO**	**Notes**
Easy going	Y	N	
Tolerant of frustration	Y	N	
Confident	Y	N	
Tried new things	Y	N	
Social, outgoing	Y	N	
Quiet	Y	N	
Calm	Y	N	
Interactive, making good eye contact	Y	N	
Kind, sensitive to others	Y	N	
Flexible	Y	N	
Independent	Y	N	
Shy/Anxious	Y	N	
Separation Anxiety	Y	N	
Cuddly (liked to be held)	Y	N	

Describe the relationships your child has with friends, family, school personnel, etc.

Name	Relationship to child	How does he get along with this person?	Comments
Example: Sally	***Mom***	***He enjoys her but he is more oppositional and defiant with her than he is with others.***	***Sally is very frustrated by his behavior and is very upset about his lack of respect.***

Please describe your child's ability to socialize and make friends:

_____

_____

_____

What school does your child go to?_____

How is your child doing in school currently?_____Grades?_____

Does your child have any learning disabilities or problems?_____

Has your child had neuropsychological testing? Yes No If yes, please fax a copy to us or bring it to the evaluation with you.

Has your child ever been abused or neglected? Yes____ No_____

Has your child ever experienced a traumatic event that caused him/her nightmares and to avoid certain people or places? Yes ___ No___

TRAUMAS	YES	NO	NOTES
Victim of violence	Y	N	
Victim of sexual abuse	Y	N	
Witnessed violence	Y	N	
Separation from parent(s)	Y	N	
Death in family	Y	N	
Out of home placement	Y	N	
Divorce/separation	Y	N	
Other traumatic experience	Y	N	

Does your child have a therapist? Yes No If yes, please provide name, phone and fax # for therapist:

Date therapy started or ended:

Has therapy been helpful in the past or present? Yes No

<u>Behaviors and Symptoms</u>

Describe your child's strengths:

Describe your child's weaknesses:

Your notes regarding dangerous behaviors:

Hits or punches others when angry	Never	Past	Sometimes	Often	Always
Threatens to hurt or kill others	Never	Past	Sometimes	Often	Always
Hurts self (cutting, head-banging)	Never	Past	Sometimes	Often	Always
Threatens suicide	Never	Past	Sometimes	Often	Always
Has attempted suicide	Never	Past	Sometimes	Often	Always
Stays out all night	Never	Past	Sometimes	Often	Always

Defiant with adults at school/talks back	Never	Past	Sometimes	Often	Always
Defiant with adults at home/talks back	Never	Past	Sometimes	Often	Always
Argues with adults	Never	Past	Sometimes	Often	Always
Refuses to do what he/she is told by adults	Never	Past	Sometimes	Often	Always
Easily frustrated	Never	Past	Sometimes	Often	Always
Angry or resentful	Never	Past	Sometimes	Often	Always
Spiteful or vindictive	Never	Past	Sometimes	Often	Always
Annoys others deliberately	Never	Past	Sometimes	Often	Always
Blames others for his/her mistakes	Never	Past	Sometimes	Often	Always

Write your notes regarding defiant and disruptive behaviors here:

Trouble listening to directions/following through	Never	Past	Sometimes	Often	Always
Disorganized	Never	Past	Sometimes	Often	Always
Easily distracted from tasks	Never	Past	Sometimes	Often	Always
Loses things necessary for task completion	Never	Past	Sometimes	Often	Always
Trouble focusing to complete tasks	Never	Past	Sometimes	Often	Always
Forgetful	Never	Past	Sometimes	Often	Always
Driven or hyperactive	Never	Past	Sometimes	Often	Always
Fidgety/squirmy	Never	Past	Sometimes	Often	Always

Trouble staying seated	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Too loud/talks too much	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Trouble taking turns, waiting	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Interrupts, butts in	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Blurts answers before hearing the whole question	**Never**	**Past**	**Sometimes**	**Often**	**Always**

Please describe problems with focus, concentration, and impulse control here:

If you suspect your child has ADHD, please fill out the ADHD rating scale and the DBD scale on the website and fax it to the office or bring it with you to the visit. You may also have the teachers fill out the Vanderbuilt ADHD scale and the DBD scale.

Seems sad	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Talks of death	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Can't seem to have fun, losing interests	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Cries	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Talks of feeling guilty	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Talks of feeling worthless	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Talks of being hopeless that things will improve	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Talks of feeling helpless to make things better	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Listless, lacking energy	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Lacking motivation	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Sick, tired, achy, physical complaints	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Can't fall asleep	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Can't stay asleep	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Sleeps too much	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Eats too little (losing weight)	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Eats too much (gaining weight)	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Excessive/distorted concern about body weight	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Binge eating	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Vomiting or using laxatives to lose weight	**Never**	**Past**	**Sometimes**	**Often**	**Always**

Starvation diets or excessive exercise	**Never**	**Past**	**Sometimes**	**Often**	**Always**

Other depressive behaviors: (specify):

***If your child has depressive symptoms, please fill out child depression rating scale on website and fax or bring it to visit.**
Write your notes regarding above symptoms here:

Odd or unusual bursts of energy	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Shouts at others and starts fights	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Unusually self-confident and socially outgoing	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Able to get by on a lot less sleep than usual	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Much more talkative than usual	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Unusual pressure to speak (rushing words)	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Unusually distracted by things around him/her	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Trouble concentrating	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Eager to take on many more projects than usual	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Unusually/excessively interested in sex	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Does things that are extremely foolish or risky	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Spends excessive amounts of money	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Other odd mood shifts (specify)	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Persistently Irritable	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Overreacts to insignificant triggers	**Never**	**Past**	**Sometimes**	**Often**	**Always**

Write your notes regarding above symptoms here:

Excessive worries or fears	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Difficulty separating from familiar people	**Never**	**Past**	**Sometimes**	**Often**	**Always**

Panic attacks	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Trouble leaving home	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Checking rituals	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Counting rituals	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Washing rituals	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Upsetting thoughts that won't go away	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Panicked around unfamiliar people	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Physical symptoms when upset	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Excessive worry about illnesses	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Too nervous to face going to school	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Nightmares	**Never**	**Past**	**Sometimes**	**Often**	**Always**
On the look-out for dangers	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Other anxieties (specify)	**Never**	**Past**	**Sometimes**	**Often**	**Always**
	Never	**Past**	**Sometimes**	**Often**	**Always**
	Never	**Past**	**Sometimes**	**Often**	**Always**

***If your child has anxiety symptoms, please fill out parent anxiety rating scale on website and fax or bring to visit.**
Write your notes regarding above symptoms here:

Hears voices that no one else hears	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Sees visions	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Has odd ideas or beliefs that couldn't be true	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Believes imaginary friends are real	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Behaves in a way that others consider odd	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Gradual neglect of hygiene	**Never**	**Past**	**Sometimes**	**Often**	**Always**
Other strange or bizarre behaviors (specify)	**Never**	**Past**	**Sometimes**	**Often**	**Always**
	Never	**Past**	**Sometimes**	**Often**	**Always**
	Never	**Past**	**Sometimes**	**Often**	**Always**
	Never	**Past**	**Sometimes**	**Often**	**Always**

Write your notes regarding above symptoms here:

What questions would you like to have answered at this evaluation?
1.
2.
3.

Please note areas of active concern about the referred child (specifics will be recorded on later pages):

	YES	NO
Behavior dangerous to others	Y	N
Behavior dangerous to self	Y	N
Experimenting with drugs or alcohol	Y	N
Defiant of adult authority	Y	N
Problems with focus and attention	Y	N
Depressed moods	Y	N
Elevated, irritable, or manic moods	Y	N
Anxieties, fears, phobias	Y	N
Confusion about what is real and what is not	Y	N

Duration of symptoms is an important diagnostic consideration. If mood disturbance is a concern, how long are the continuous periods when mood seems distinctly abnormal and the child is not behaving like his/her usual self?

	MINUTES	HOURS	DAYS	WEEKS	MONTHS
Duration of continuous mood disturbance					

HOW DOES YOUR CHILD DO IN SCHOOL?
Check and note approximately when the problem started:

Reading	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Math					

Written Expression					
Relationships with Peers					
Following Directions					
Disrupting Class					
Completing assignments					
Organizational skills					

If the child has an Individualized Education Plan (IEP) or a 504 plan:

Nature of disability:

Services offered:

Your suggestions for improvement:

Behavior and Consequences:

How often do you need to use punishment/consequences for problem behaviors?

Which type of consequences are used for problem behaviors?

How often do you provide positive reinforcement/rewards for good behaviors?

Which type of positive reinforcement/rewards are used?

MEDICAL HISTORY

It is important to provide a history of any psychiatric medications that your child has taken in the past, including the dates they were taken, and his/her response to them. Please send a copy of this medical release of information to your previous prescriber and to your pediatrician with a request for them to fax or mail your child's medical records. Please do this right away as it takes time for them to process.

FAX: 781-374-7552

LIST OF PAST MEDICATIONS

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 CONTINUED

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/Bowel Problems			Kidney Problems		

Any other medical problems? Please Describe:

Has your child had surgery? If so, Please Provide type of surgery and dates:

Does your child have any allergies?
Does your child have any allergies to drugs? If so, please list drug and what happened:

Is your daughter sexually active? Yes____ No____
Is she using a reliable form of birth control? Yes____ No____ If yes, please list: _____
Is there any chance that your daughter could be pregnant? Yes____ No____

When was your child's last physical? _____. Date of last Blood Draw?_____

Please contact your primary care doctor and ask them to fax a copy of your last visit, along with medical history (including any previous diagnosis of medical or psychiatric disorder and a copy of your most recent labs) to your provider prior to your appt.
FAX #: 781-374-7552

FAMILY HISTORY OF PSYCHIATRIC DISORDERS

Family History	Yes	No	Who? (Relation to child). Please explain diagnosis or symptoms.
Heart disease	Y	N	
Sudden death (heart stopped out of the blue)	Y	N	
Diabetes	Y	N	
Psychosis, schizophrenia, or nervous breakdowns	Y	N	
Psychiatric Hospitalizations	Y	N	
Bipolar disorder or manic-depressive disorder	Y	N	
Explosive temper/violent behavior	Y	N	
Suicidal thoughts or suicide attempts	Y	N	
Alcohol or drug addictions	Y	N	
Depression	Y	N	
Anxiety or panic attacks	Y	N	
Attention-Deficit Hyperactivity Disorder (ADHD)	Y	N	
Antisocial or criminal behavior	Y	N	
Other conditions (specify)	Y	N	

Has your child ever abused drugs or alcohol? Yes ___ No___. Please list substance(s) with approximate use dates in the past along with any treatment received:

_____

_____

Has anyone ever been concerned about your child's alcohol use? Yes ___ No___. If yes, please explain:_____

_____

How often does your child currently drink alcohol? #_____ drinks per event, #_____ times per week.

How often does your child smoke marijuana? #____times per day, #____ times per week. How much do they smoke at each occurrence?

_____

How often does your child take other illicit drugs? # ____times per day, #___ times per week. Please list other drugs being used currently:

_____

Has your child ever had suicidal thoughts or attempted suicide? Yes ___ No___. If yes, When and what led up to this?

_____

Has your child ever had homicidal thoughts or violent behavior? Yes ___ No___. Please explain:

_____

Has your child ever been hospitalized for emotional or behavioral problems? Yes ___ No___. If yes, please list:
Name of Hospital Dates Hospitalized Reason for Hospitalization

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_____

Insurance and Payment Policies (page 1 of 2)

For Blue cross blue shield patients: We accept most Blue Cross Blue Shield plans. However, if you have an out of state BCBS plan or medicare or medicaid in addition to BCBS, they may not cover services at SSPS. You should call to verify if you are covered for services at SSPS. Give them NPI # 1588062244 to be sure you are covered at this office. **Co-payments must be made at the time of the visit by cash, check, credit card, debit or medical benefit card. An invoice of fees for services provided by SSPS will be sent directly to BCBS on your behalf but you are personally responsible for any fees that are not covered by your plan. If you have a high deductible, you will need to pay out of pocket at the time of the visit until your deductible is met. An invoice for services will be sent to BCBS so it will be applied to your deductible. If your insurance coverage changes at any time, it is your responsibility to provide the new insurance card to the clinician at the time of the visit. If this is not provided, the claim may be denied and you will be responsible for the payment.**

For all other patients: SSPS is not on any insurance panels (other than BCBS) so we are considered an "out of network provider". We do not bill insurances other than BCBS. Most PPO insurance plans will reimburse patients for out of network visits but rates vary so you should check with your company. **All fees for services must be paid at the time of the visit by cash, check, credit, debit or medical benefit card.** We will provide a receipt for you to submit to your insurance company for reimbursement. We advise you to check with your insurance about coverage and deductibles so you will not be surprised by fees that they don't cover.

All patients are responsible for payment at the time of the services that are not covered by insurance.

Office Cancellation and Overdue Balance Policy (2 of 2)

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 and our clinicians rely on income from scheduled appointments). **Due to the high number of patients not showing up for appointments, last minute cancelations and unpaid overdue balances, we are now forced to collect 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 minimum cost of a 30-minute appointment ($150).** **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 and you can avoid being charged.

We send out text reminders of appointments as a courtesy. However, you are responsible to keep track of your appointment. *Not receiving a text reminder does not absolve you from being financially responsible for a missed appointment.

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 and I give permission for SSPS to charge my credit card for the fees noted above only.

Client Signature_____ **Date:**_____
****THIS PAGE MUST BE COMPLETELY FILLED OUT AND SIGNED PRIOR TO SEEING YOUR PROVIDER AT THE FIRST VISIT.**

SSPS 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 an appointment, 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. **We require 7 days notice for any refill requests as we are not in the office every day and may not be available for non-emergencies during vacations, conferences, etc. Refills are not processed on Fridays, Saturdays or Sundays as the office is closed.** We do not accept refill requests from pharmacies so do not rely on them to call the office as they will not be filled. Refill requests are only accepted from our patients or their guardian directly by phone at 781-837-8833.

*****ALL PATIENTS MUST BE SEEN AT LEAST ONCE EVERY 3 MONTHS TO ENSURE PROPER MONITORING AND GUIDANCE AND TO OBTAIN PRESCRIPTION REFILLS.**

EMERGENCIES ONLY

For true medical or psychiatric emergencies, go to the nearest emergency room and have the ER doctor contact your provider: Dr. Mary Ann McDonnell at 781-424-5782.

**This number should not be used unless it is a true psychiatric/medical emergency! For non-emergency issues, please call the main office number at 781-837-8833 and someone will get back to you within 24 working hours on Mondays through Fridays. Messages are not routinely checked on the weekends. I have received a copy and I agree to comply with the office policies.

Signature_____Date_____