Materia Medica

Matthew F. Donnelly, PA-C
2804 Del Prado Blvd S Suite 109
Cape Coral, FL 33904
(239) 223-0039 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:_____

SPOUSE OR PARENT EMAIL:_____

AGE: _____MARITAL STATUS_____SSN#: _____

EMPLOYER OR SCHOOL (IF STUDENT): _____

REFERRED BY:
_____PHONE:_____

PERSON TO CONTACT IN AN EMERGENCY:

_____
NAME RELATIONSHIP PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE: _____NAME OF PRIMARY 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:_____

SECONDARY INSURANCE:_____NAME OF INSURED:_____

SECONDARY POLICY #:_____SECONDARY GROUP #:_____

OFFICE USE ONLY:
Primary Diagnosis_____ **Secondary Diagnosis**_____

TREATMENT AGREEMENT:

PLEASE INITIAL:
CO PAYMENTS, DEDUCTIBLE, AND/OR COINSURANCE ARE DUE AT THE TIME OF SERVICE. _____

I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO MATERIA MEDICA. WHILE MATERIA MEDICA 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. _____

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

FEES ARE $300.00 FOR THE INITIAL SESSION, 60 MINUTES, AND $150.00 FOR SESSIONS, 30 MINUTES. _____

YOU WILL BE CHARGED $100.00 FOR MISSING AN APPOINTMENT OR NOT GIVING AT LEAST 24 HOURS PRIOR NOTICE TO CANCELING AN APPOINTMENT. _____

THERE WILL BE A $25.00 CHARGE FOR ANY AND EACH REQUESTED LETTERS, INCLUDING, BUT NOT LIMITED TO, DISABILITY PAPERWORK—SSDI, SSI, LONG TERM, OR SHORT TERM, SUPPORTIVE ANIMAL THERAPY, MEDICAL MARIJUANA PAPERWORK, AND FMLA. PLEASE NOTE THAT PAPERWORK SUBMISSION IS NOT A REIMBURSABLE BY INSURANCE._____

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.

PATIENT SIGNATURE: _____**DATE**: _____

TO ENABLE MATERIA MEDICA WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:
PLEASE BE AWARE THAT FAX TRANSMISSIONS ARRIVE AT MATERIA MEDICA. 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:

NAME OF YOUR PRIMARY PHYSICIAN: _____MAY WE CONTACT? _____

PHONE NUMBER: _____ WHEN WERE YOU LAST SEEN? _____

I **GIVE MY CONSENT** FOR **MATERIA MEDICA** TO RELEASE MY RECORD TO MY PRIMARY PHYSICIAN SO THAT THEY CAN DISCUSS MY TREATMENT:

SIGNED_____DATE_____

I DO NOT **GIVE MY CONSENT** FOR **MATERIA MEDICA** TO RELEASE MY RECORDS TO MY PRIMARY PHYSICIAN:

SIGNED_____DATE_____

PLEASE LIST ALL CURRENT MEDICATIONS, INCLUDE OVER THE COUNTER MEDICATIONS:

NAME	**DOSAGE**	**PRESCRIBING PHYSICIAN**

PHARMACY NAME, LOCATION, AND PHONE NUMBER:_____

_____

MEDICATION ALLERGIES:_____

_____

_____

PRESCRIPTION RENEWAL AND REFILL POLICY

- IT IS IMPERATIVE THAT YOU INFORM MATERIA MEDICA AND MATTHEW F. DONNELLY, PA-C OF ALL MEDICATIONS THAT YOU ARE PRESCRIBED FROM ANOTHER PHYSICIAN.
- OUR OFFICE POLICY IS THAT PRESCRIPTIONS ARE REFILLED **ONLY** DURING BUSINESS HOURS, MONDAY THROUGH FRIDAY, 9AM TO 5PM.
- PRESCRIPTIONS WILL NOT BE FILLED AFTER HOURS, AT NIGHT, ON WEEKENDS, OR HOLIDAYS.
- IF YOU ANTICIPATE THE NEED TO REFILL YOUR PRESCRIPTION PRIOR TO YOUR NEXT APPOINTMENT, PLEASE CALL AT LEAST 3 BUSINESS DAYS OR 72 HOURS TO ALLOW FOR PROCESSING TO REFILL YOUR PRESCRIPTION.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY REGARDING PRESCRIPTION MEDICATIONS.

_____

PRINTED NAME OF PATIENT

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

Patient Form Completion Fees

Please note that insurance companies do not reimburse for time spent filling out paperwork, no matter the nature of paperwork. The following fees are per form, not per occurrence. For example, if you require a form to be filled out monthly, then, each month, the fee is applicable.

Please Initial:

_____Long Term Disability: $60.00

_____Short Term Disability: $50.00

_____FMLA Paperwork: $35.00

_____Social Security Disability, excluding initial faxing of records: $35.00

_____Medical Records sent to Other Medical Offices: No Charge

_____School Medication Forms: No Charge

_____Other Forms: Call Office

_____Please allow up to two weeks for records requests to be processed.

_____If you require immediacy in filling out forms/requesting records, additional fees may be incurred.

_____Paperwork and/or records will not be released until all fees are paid.

I acknowledge the aforementioned fee schedules and agree to pay the requested fees for forms, records, letters, or paperwork.

_____ _____

Signature Date