Timothy C. Donovan, LCSW-C
MEDPSYCH ASSOCIATES AT GREENSPRING STATION
2324 WEST JOPPA ROAD, SUITE 220
LUTHERVILLE, MARYLAND 21093
PHONE: (410) 583-2622
FAX: (410) 583-2949
Email: tcdonovan2002@yahoo.com

Name_____, Date of Birth_____
Age_____, Address_____
City_____, State_____, Zip_____
Home Phone_____, Cell Phone_____
Email_____, Gender: Female____, Male____
Marital Status: Single, _____, Married_____, Divorce_____, Widow (er)_____
SSN#_____, Occupation_____
Student/Grade_____, Referred by: _____
Primary Physician & Phone#_____

Responsible Party – Who Is Responsible For The Account?

Name_____, Relationship to patient_____
Address_____
City_____, State, _____Zip_____
Home Phone_____, Cell Phone_____
Employer_____, Occupation_____
Address_____
City_____, State_____, Zip_____, Work Phone_____

In Case Of Emergency
In the event of an emergency, whom should I contact? If patient is a minor, PARENT/GUARDIAN must fill out.
Name_____, Relationship_____
Home Phone_____, Cell Phone_____
Work Phone_____, Email: _____

Financial Policy
Cancellation Policy: I understand that twenty-four hour notice must be given for cancelled appointment(s) or I will be responsible for the full fee of the missed appointment(s). Signature_____
ALL FEES ARE DUE AT THE TIME OF SERVICES RENDERED

Consent to treatment

With My signature below, I give permission and consent to Timothy C. Donovan, LCSW-C to provide psychotherapeutic services. Services may include initial evaluation, with myself, members of my family or others providers (with expressed written or verbal consent) and psychotherapy (individual, group, family or marital therapy). This consent will apply to myself, and if applicable,

_____

Who is my child and for whom I have legal custody and power to consent for mental health treatment.

Signature of Patient or Parent/Guardian_____

Presenting Problem(s) In Order Of Priority

1.

2.

3.

4.

5.