Mary Cullinane, M.S., LMHC

Phone: (716) 713-4367
mefcullinane@gmail.com

My Qualifications:

After completing my Master's degree in Counseling Psychology from Loyola University Maryland in Baltimore, MD in 2005, I received specialized training in mental health treatment through counseling at various programs in Baltimore, San Antonio, TX, and back home in Buffalo. My counseling settings have included medication-assisted addiction treatment programs, outpatient community counseling programs, specialty programs for eating disorders, and private practice. I earned my License in Mental Health Counseling (LMHC) in New York in 2012.

Purposes, Goals, and Techniques:

Counseling provides an objective relationship that often leads to a reduction in distressing feelings, resolution of specific problems, more satisfying relationships with others and improved methods of coping. However, you often "get out what you put in" and there are no guarantees. Counseling is a process that involves examining your life, problems, relationships and behaviors, including feelings and memories that may be sensitive and difficult. Successful counseling requires trust, time and commitment to the process. Cognitive-Behavioral Therapy (CBT) techniques will likely be incorporated in the process, and will involve identifying your thinking pattern and its direct relationship with your feelings.

In our initial session, we will work together to decide the goals of treatment. If at any time, you or I believe that a different mode of treatment would be in your best interest, I will offer alternative resources.

Confidentiality

My practice is in compliance with New York State HIPAA regulations. Although this paperwork provides you with a summary of these regulations, I would be glad to provide you with a complete written copy upon request. In general, all communications between a patient and a therapist are protected by law and are kept in strict confidence. I can only release information about our work to others with your written permission. Although I may request your permission to communicate with specific individuals (e.g., your primary care physician), this is your choice and I must have written permission before such communication takes place. This permission may also be revoked in writing at any time. Confidentiality, however, is not absolute. There are several situations in which confidentiality cannot be guaranteed including, but not limited to, the following.

- You or someone else appears to be in immediate danger
- There is a reason to suspect that child abuse or neglect has occurred
- A court orders the release of information
- An insurance company requires information to substantiate a claim

Confidentiality as it relates to Minors

For psychotherapy to be most effective, children must feel safe with the therapist and understand that the therapist will not tell others about specific things which are discussed. Yet, the situations mentioned above apply to minors as well as to adults. In addition, it needs to be understood that parents or guardians need to know how their child or adolescent is progressing in therapy. It is also understood that general concerns and issues will be discussed with parents as well as specific topics the therapist and

minor client have mutually decided to discuss with family members or the guardian. Lastly, patients twelve and over will be notified when information is shared with outside sources.

Release of Information to Primary Care Physicians and Other Parties.

I am required to obtain detailed information on each client and each client's family. Often, it is also helpful to release information from your records to your primary care physician or other physicians involved in your care. The purpose of this is to coordinate care so that you can receive the most consistent, integrated care possible. Sometimes, there are other individuals or agencies that are involved in your situation, such as nutritional therapists or school personnel. I am happy to release information and coordinate care to such parties per your specific written requests.

Payment policy:

Current counseling fees (as of January 2021)

-$125.00 for initial intake session (60 minutes).

-$100.00 per individual session (45-50 minutes).

-Full payment is expected at the beginning of each session, unless a prior arrangement is agreed upon.

-Acceptable methods of payment are cash, check, Venmo (@Mary-Cullinane), Paypal (mefcullinane@gmail.com), Mastercard, Visa, Discover, and AmericanExpress. **Venmo and Paypal are the only accepted payments for Telehealth appointments, and must be received prior to beginning of appointment.**

Insurance:

I am considered an "out of network" provider with most insurance companies, as I do not directly contract with any at this time. Some insurance plans will reimburse you for use of out of network providers, and I'm happy to provide you with the necessary documentation to do this if requested.

Cancellation Policy:

If you do not cancel a scheduled appointment, I am unable to use that time for another client. A 50% fee ($50) will be charged for appointments not canceled without 24-hours notice.

Methods of Contact/Emergency Plan:

If needing to contact me outside of our scheduled appointment times, you may call me at (716) 713-4367 during working hours (9am-5pm Monday-Friday) or e-mail me at mefcullinane@gmail.com. I will return your call or e-mail as soon as I am able during working hours. If you're experiencing an emergency, please call 911 or Crisis Services at (716) 834-3131 or Comprehensive Psychiatric Emergency Program at ECMC at (716) 898-3465.

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Consent for Treatment

I have been informed of my rights and responsibilities as a client and agree to the policies outlined in Mary Cullinane's practice paperwork. These include her description of the nature of therapy, confidentiality, release of Protected Health Information, fee and cancellation policies, and emergency procedures. I understand that I have a right to know Mary Cullinane's treatment plan for myself (or my child) and may ask questions about that at any time.

Please sign below if you understand and agree to these policies.

_____
Patient Name (printed)

_____
Date of Birth

_____ _____
Patient Signature (required for age 13 and over) Date

_____ _____
Parent or Guardian Signature Date

CONSENT AND AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I hereby give Mary Cullinane my permission to release and exchange all pertinent **medical, school, psychological, and psychiatric information** with the following person(s), agencies, or organizations for the purposes of coordination of treatment, claim reimbursement, insurance authorization, and utilization review:

Primary Physician: _____

Insurance: ____**N/A**_____

Other Parties: _____

I have read the above information, and I authorize Mary Cullinane to disclose such information as listed above. I understand that this consent may be withdrawn by me at any time, except to the extent that action has been taken in reliance upon it. I release all parties and their personnel from any liability resulting from the release of this information with the understanding that they will exercise reasonable professional safeguards regarding the confidentiality of this information.

_____ _____
Patient Name (printed) Date of Birth

____ _____ _____
Patient Signature (required for age 13 and over) Date

_____ _____
Parent or Guardian Signature Date

Patient General information

Phone number_____
Address _____
Emergancy contact (name, relationship, #) _____

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Notice of privacy practice
Informed consent for emails, SMS text and video conference contact

In order to communicate with you by email or video conference, I need to make sure you are aware of confidentiality and other issues that arise when I communicate this way.

I understand that messages/contact by email, text and video conference are not encrypted, are not secure and may be read by others. I can NOT guarantee confidentiality and security of any information I send, or you send to me via email, text and/or video conferencing.

I hereby give permission to Mary Cullinane, LMHC to reply to my messages via email, text or video conferencing.

I agree that Mary Cullinane, LMHC shall NOT be liable for any breach of confidentiality that may result from this use of email, texting, or video conferencing.

I also understand that I may withdraw permission from Mary Cullinane, LMHC to communicate with me via email, texting, and video conferencing by written notification.

_____ (signature)

_____ (date)