Frances Wollman Baumgarten PhD
3419 Via Lido #353
Newport Beach CA. 92663
949-474-8442

NEW PATIENT INFORMATION

Today's Date _____

Patient's Name _____

Date of Birth _____ Age _____

Address_____
Street City State Zip Code

Telephone _____
Home Cell Work

Employer/School_____Occupation_____

Legal Status: Single Married Separated Divorced Widowed Living Together

Primary Care Physician _____Telephone_____

Referred By_____

Person To Be Contacted In Case Of Emergency

Name _____ Telephone Home_____

Relationship _____ Telephone Cell_____

PATIENT SIGNATURE_____

Medical History:
Prescription Drugs /Over The Counter Medications.

_____
Medical Conditions Present and Past.

_____
Psychiatric History:
Outpatient Therapy Dates and Professional Names:

_____
Inpatient Therapy Dates and Hospital Names

_____
Medications Prescribed and Psychiatrist's Name.

_____
Family History:
Describe Medical or Psychiatric Conditions of any Relatives.

_____

Habits:	Amounts Currently Using	Most Ever Used
Coffee (cups/day)		
Cigarettes (Packs/day)		
Alcohol		

Substance Abuse History: Yes No
If Yes please describe:

Substance	Amount	Frequency	When (First use/Last use)

Do you have a history of Blackouts? Yes No

Please Check all Symptoms and Concerns.

Depressed Mood	Hyperactivity	Sleeping Patterns
Decreased Energy	Intrusive Thoughts	Eating Patterns
Hopelessness	Delusions	Sexual Functioning
Guilt	Hallucinations	Difficulty Paying Attention
Anxiety	Paranoia	Difficulty Concentrating
Panic Attacks	Periods of Dissociation	Impulse Control
Irritability	Physical Abuse	Anger Management
Worthlessness	Sexual Abuse	Suicide Ideation/Attempts
Grief	Assaults	Homicide Ideation
Worry/Fears	Physical Complaints	Other_____

Recent Changes in Lifestyle.

Friendships	Finances	Living Arrangements	Hobbies
Family	Health	Job/School	Legal

PATIENT SIGNATURE_____

PLEASE READ CAREFULLY AND INITIAL EACH SECTION AS ACCEPTANCE OF THESE CONDITIONS.

1) LIMITATIONS OF PATIENT CONFIDENTIALITY.

In general the privacy of all communication between a patient and a psychologist is protected by law, and I can only release information about our work with your written permission.

But there are a few exceptions:

(A) In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony, and or your records. if he/she determines that the issues demand it, and I must comply with court orders. An example of a time when your information might be court ordered is if have filed a suit against anyone and have claimed mental or emotional damages as part of the suit.

(B) I am also legally obligated to take protective action and notify the appropriate authorities, and others who can help provide protection, If one of these situations occur in he course of our work together, I will attempt to fully discuss it with you before taking any action.

- If you are a danger to yourself or others, or unable to take care of yourself.
- If a child, elder or disabled person is being or has been emotionally, physically or sexually abused.
- If you are under 16 years old and you are the victim of a crime.

INITIAL_____

2) FINANCIAL TERMS

Payment is due at time of service unless other arrangements have been made prior to this session. Sessions are 50 minutes in length unless otherwise planned. If you use the app for electronic payment confidentiality and privacy cannot be guaranteed. However, app invoices will only say Telehealth Consultation, they will never have any diagnosis codes or other private information. Paper invoices and super bills are available upon request.

INITIAL_____

As a fee for service practice, **Medicare Cannot be billed or invoiced for these services. Your signature signifies your agreement not to bill Medicare.** _____Initial

3) CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that an hour appointment time is reserved only for you.

If an appointment is missed or canceled with less than 24-hour notice, you will be billed for the hour.

INITIAL_____

4) CONSENT FOR TREATMENT

I understand how stressful having cancer is (or having a family member who has/had cancer) and the many emotional, psychological, relationship and life style challenges that accompany the diagnosis, treatments and recovery, as well as terminal and grief stages. I am here to help you develop strong coping skills that will enable you to process these challenges, deal with the emotional struggles, minimize the emotional pain and maximize strengths so that you can maintain as productive a life as possible.

PATIENT SIGNATURE_____

Frances Wollman Baumgarten, PhD
3419 Via Lido #353
Newport Beach, CA 92663

CONSENT TO RELEASE AND RECEIVE INFORMATION:

This consent is for Dr. Baumgarten to contact by telephone, or/and to send copies of these records to one or all of the following health care providers:

Nurse Navigator **Primary Care Physician** **Psychiatrist** **Oncologist**

Name:_____

Phone: _____

Address:_____.

For developing, implementing and providing a comprehensive treatment plans.

Patient's Name: _____
(Please Print)

Patient's Signature:

_____**Date:**_____

Guardian or Parent's Signature if patient is under 18.

_____**Date:**_____

This consent is valid for as long as the patient is in treatment with Dr. Baumgarten unless a hard-written copy of notification is provided. Please feel free to contact me in writing if you wish to change these consents. I cannot guarantee that a message left by phone, text or email will be received. Therefore, these messages will not be sufficient consent to change this permission form,

- **I do not give my permission to release any information to any health care providers.**
- **I understand that if I send a bill to my insurance carrier they may request records.**

PATIENT SIGNATURE_____

CONSENT TO CONTACT

I GIVE PERMISSION FOR DR. BAUMGARTEN TO CONTACT ME IN THE FOLLOWING MANNER.

TELEPHONE:

Home_____ Consent to leave a message Yes. No

Cell_____Consent to leave a message. Yes. No
Consent to leave a Text message. Yes. No

Work_____ Consent to leave a message Yes No

EMAIL_____
Consent to Receive: Invoices, Appointments, Telehealth Consents, Confidential Information, Responses to Questions

MAIL:

Address that we can send information i.e.: bills, statements.

_____

_____

Please feel free to contact me in writing if you wish to change these consents.
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Therefore, these messages will not be sufficient consent to change this permission form.

Patient Signature_____Date_____

PATIENT SIGNATURE_____