Frances Baumgarten, Ph.D.
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 Work

Employer/School ________________________________Occupation/Grade_________________________

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 Work ______________________

PATIENT SIGNATURE____

Patient Information

Medical History:

Prescription Drugs /Over The Counter Medications:

___

Medical Conditions Present and Past:

___

Psychiatric History:

Outpatient Therapy Dates and Professional's Name:

___

Inpatient Therapy Dates and Hospital Names:

___

Medications Prescribed and Psychiatrist's Name:

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Family History:

Describe Medical or Psychiatric Conditions of any Relatives:

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

Substance Abuse History: **Yes. No**

If Yes please describe:

Substances	Amounts	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	Disruption of Thoughts	Eating Patterns
Hopelessness	Delusions	Sexual Functioning
Guilt	Hallucinations	Difficulty Paying Attention
Anxiety	Paranoia	Difficulty Concentrating
Panic Attacks	Periods of Dissociation	Impulse Control
Phobias	Memory Loss/ Recall Difficulty	Self Harm/ Cutting
Irritability	Physical Abuse	Anger Management
Worthlessness	Sexual Abuse	Suicide Ideation/Attempts
Grief	Assaults	Homicide Ideation
Worry/Fears	Physical Complaints	Other__________________

Recent Changes in Lifestyle. Circle all that apply.

Family Finances. Living Arrangements. Health Friendships. Job/School Hobbies Legal

PATIENT SIGNATURE____

PLEASE READ CAREFULLY AND INITIAL EACH SECTION AS ACCEPTANCE

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 a copy of your records, if he/she determines that the issues demand it, and I must comply with all court orders. An example of a time when your information can be court ordered to be released is if you have filed a suit against anyone and have claimed mental or emotional damages as part of the suit.

(B). I am also required by law to disclose the following information to the appropriate authorities:

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

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 a 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

Therapy is a joint effort, the results of which can not be guaranteed. Progress depends on many factors, including motivation, effort, follow through and other life circumstances such as your interactions with family, friends and other associates. Although therapy is designed to be helpful, at times it may be difficult and uncomfortable.
As a team we will agree upon a treatment plan (to include defining the problems, goals and treatment recommendations). We will regularly discuss and evaluate the progress of the treatment and change or modify the treatment plan as necessary.

INITIAL_____

PATIENT SIGNATURE____

Frances Baumgarten, Ph.D.
1000 Quail Street #187
Newport Beach, CA 92660
949-474-8442

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:

Primary Care Physician Psychiatrist Oncologist Nurse Practitioner/Navigator

Name: ____

Phone: ______________________**Fax:**______________________

Address: ____

.

For developing, implementing and providing a comprehensive treatment plan.

Patient's Name: ______________________________ **Date:** __________
(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 written notification is provided to Dr. Baumgarten.

( ) I do not give my permission to release any information to any health care providers.

PATIENT SIGNATURE____

CONSENT TO CONTACT

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

Telephone__________________________ Consent to leave a message Yes No

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 Invites, Confidential Notifications. Yes No

Mail: **Address that I can send information i.e.: bills, statements and letters.**

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Please feel free to contact me in writing if you wish to change these consents. I cannot guarantee that a message on my phone will be received accurately. Therefore, phone messages will not be sufficient consent to change this permission form.

Patient Signature____

Date ____