

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 \_\_\_\_\_ Occupation \_\_\_\_\_

Legal Status Married Separated Divorced 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 Couples

**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:

**Family History:**

Describe Medical or Psychiatric Conditions of any Relatives:

<b><u>Habits:</u></b>	<u>Amounts Currently Using</u>	<u>Most Ever Used</u>
Coffee (cups/day)		
Cigarettes (Packs/day)		
Alcohol		
<b><u>Substance Abuse History:</u></b>	<b>Yes.</b>	<b>No</b>
If Yes please describe:		
<u>Substances</u>	<u>Amounts</u>	<u>Frequency</u>
		<u>When (First use/Last use)</u>

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 \_\_\_\_\_

**GUIDELINES AND AGREEMENT COUPLES THERAPY.**

Couples therapy offers an opportunity to improve your partnership and resolve differences. It requires commitment, open and honest communication, patience, tolerating uncomfortable emotions, and trust that each of you will show respect for each other and the process. 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. 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.

**1) 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 written permission from both of you. 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 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 a child, elder or disabled person is being or has been abused.
- If there is a serious threat to to your life, family member or the life of another.

**(C) For Participating in Couple Sessions.** I agree to Not use the information discussed against the other party in a judicial setting of any kind. I agree to Not subpoena Dr. Baumgarten’s testimony or records in any deposition or court hearing of any kind, such as divorce or chid custody proceedings.

INITIAL \_\_\_\_\_

**2) Financial Terms.** Payment is due at time of service unless other arrangements have been made prior to this session. Sessions are 50-80 minutes in length unless otherwise planned. If you choice to use the app for electronic payment confidentiality and privacy cannot be guaranteed. App invoices will only say Telehealth Consultation, they will never have any diagnosis code or private information on them. Paper invoices and superbills are available upon request.

INITIAL \_\_\_\_\_

**3) Attendance/ Cancelled/ Missed Appointments.** A scheduled appointment means that a time is reserved for you as a couple. If an appointment is missed or cancelled with less than 24-hour notice, you will be billed for the hour. Out of respect for our work, both parties must be present for us to have a session. If one person cannot attend, even if one person shows up, the session will have to be rescheduled.

INITIAL \_\_\_\_\_

**4) SHARED INFORMATION EXPECTATIONS .** One or two individual sessions may take place for the purpose of obtaining personal history to enhance individual growth and insight which can help with gaining a new perspective on attitudes, behaviors, interactions and communication styles. However, any sensitive information revealed about present day affairs, financial difficulties that can affect the partnership, legal problems, substance abuse or gambling problems, medical concerns such as sexually transmitted diseases, will be expected to be shared with your partner either prior to our next joint session, or with my assistance in our next joint session. Phone/text/email contact will be limited to appointment scheduling.

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:**

**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,**  
Yes No

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

\_\_\_\_\_  
\_\_\_\_\_

**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** \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_