

**Thomas L. Firnberg II, M.D., Inc.**

Diplomat of the American Board of Psychiatry and Neurology

Southern California Psychiatric Associates/Anaheim Hills Psychotherapy  
130 South Imperial Hwy  
Anaheim Hills, California 92807

office # 714-627-4089 mobile # 951-533-9993 fax # 714-627-4090

E-Mail: [tfirnberg@aol.com](mailto:tfirnberg@aol.com); web page: [www.thomasfirnbergmd.com](http://www.thomasfirnbergmd.com)

**New Patient Information and Consent Form**

*To be completed by patient (or parent/guardian if patient is under age 18)*

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: h#: \_\_\_\_\_ w#: \_\_\_\_\_

cell#: \_\_\_\_\_

May we call you at home? \_\_\_\_\_ May we call you at work? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Spouse's work #: \_\_\_\_\_

Spouse's cell #: \_\_\_\_\_ May we call spouse in emergency? \_\_\_\_\_

Patient's Employer/School: \_\_\_\_\_

Patient Occupation: \_\_\_\_\_

If patient is a minor:

Name of parent or guardian:

\_\_\_\_\_

Address of parent or guardian, if different from above:

\_\_\_\_\_

\_\_\_\_\_

Person to be contacted in case of emergency:

Name: \_\_\_\_\_ Home ph #: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Work ph #: \_\_\_\_\_

Mobile ph #: \_\_\_\_\_

Insurance Information:

Health Plan: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's SSN: \_\_\_\_\_

IPA/Medical Group: \_\_\_\_\_

**Note that your account will be billed for the full amount  
if you do not show for your appointment!**

Primary Care Physician:

Name of Physician: \_\_\_\_\_

PCP Office Phone #: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

Reason for last visit: \_\_\_\_\_

\_\_\_\_\_

## **Terms of Treatment**

### **1. Financial Terms:**

Upon verification of health plan/insurance coverage and policy limits, your doctor will bill your insurance carrier for you, and he will be paid directly by the carrier. You will be responsible for any applicable deductibles or co-payments. If you are not eligible at the time services are rendered, you are responsible for payment.

Co-payments are expected to be paid at the time services are rendered. If bills are not paid in a timely manner, they will be turned over to a collection agency. A sliding scale fee adjustment is available in cases of financial duress on a case-by-case basis.

**Patient initials:** \_\_\_\_\_

2. **Cancelled / Missed Appointments:**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours' notice, you will be billed for the entire amount of the session – not your insurance company – unless an emergency has arisen. Frequent cancellations may result in termination from treatment and referral to another mental health care professional.

**Patient initials:** \_\_\_\_\_

3. **Appeals and Grievances:**

If your insurance company denies authorization for care, then you may appeal your case to the insurance company. We can appeal for you as well.

**Patient initials:** \_\_\_\_\_

4. **Emergencies:**

If you should experience a medical or psychiatric emergency in the course of your treatment with me, please **do NOT call my office or mobile phone until the emergency has been treated**. This is because **there often is a delay of several hours before I can return your call**.

Instead, the safest approach to an emergency is to go **immediately to the nearest hospital emergency room if you are able to do so safely. Otherwise, call 911 and a medical/psychiatric team will be dispatched to where you are**.

**Patient initials:** \_\_\_\_\_

5. **Non-Emergency Contact with the Doctor:**

For non-emergent problems which need discussion before your next clinic visit, I recommend first contacting me by email at: [tlfirmberg@aol.com](mailto:tlfirmberg@aol.com). Sometimes email is insufficient and telephone contact is required. In such cases, call my mobile phone number (not the front office number) and no fee will be assessed.

**Patient initials:** \_\_\_\_\_

6. **Compliance with Treatment:**

When a patient does not return for appointments as agreed upon in the previous session, it involves risk for the patient's mental health as well as legal liability for the physician, who bears legal responsibility for the patient's treatment. If you do not return for appointments as agreed upon, your case automatically goes into a state of legal **non-compliance**, and the physician is no longer legally responsible for your condition. In such a case, you will be notified by phone or letter of the situation, and your case will be formally closed via letter until you are seen again in clinic.

Whenever your case is closed, **the physician will not be able to fill prescriptions for you**, and your pharmacy will be notified accordingly. Usually your case can be re-opened simply by being seen again in clinic – phone consults are insufficient in such a case. If more than six months has passed since your last exam, a full, one-hour evaluation will be required to re-open your case. Please note that repeated case-

closures may necessitate permanent case-closure and referral to another mental healthcare professional.

**Patient initials:** \_\_\_\_\_

7. **Confidentiality:**

All information exchanged between you and your doctor is held in strict confidentiality. Your medical records also are kept in locked containers in the office, and you have the legal right to access to your records at any time. The physician is merely the legal custodian of your records. There are exceptions to the rule of confidentiality, namely:

- a. If you (or your legal guardian) sign a **release of information document** with me in order that I might discuss your case with a collaborating health care worker, which may involve telephone contact, transmission of copies of your medical records, etc.
- b. If you should present a **danger to yourself**.
- c. If you should present a **danger to others**.
- d. If you should lead the physician to believe that you are **abusing children or the elderly**.
- e. If you should be so **gravely mentally disabled** that you cannot provide for your needs for food, clothing, and shelter.
- e. If your care is covered by an insurance company, a limited amount of information concerning your treatment will be need to be released to the **insurance company**.

In case of **c.** or **d.** above, the physician is **required to inform possible victims and law enforcement authorities** so that protective measures may be taken. In the cases of **b.** and **e.** above, efforts will be made to arrange transportation to the nearest hospital for treatment. In uncommon cases where the examining team judges the patient to be an immediate danger to himself or gravely mentally disabled but the patient will not go voluntarily, the dispatched examining teams are authorized under California law to transport a patient involuntarily to the hospital, where the patient can be held for 72 hours before appearing before a judge for review.

**Patient initials:** \_\_\_\_\_

8. **Consent for Treatment:**

“I hereby authorize and request that Thomas L. Firnberg II, M.D., may carry out psychiatric examination, treatment, and/or diagnostic procedures upon me which now or during the course of my care as a patient may be advisable. I understand that the purpose of this treatment will be explained to me before and during the course of

treatment, along with safe and effective alternatives for treatment and possible side effects/adverse effects. **I understand that, while my treatment is designed to be helpful, adverse effects and outcomes may occur, despite the best efforts of the physician.**”

**Patient initials:** \_\_\_\_\_

**9. Release of information to my Primary Care Provider (PCP):**

“I hereby authorize Thomas L. Firnberg II, M.D., to release information about my psychiatric care to my primary care provider (name, address, telephone, and fax): \_\_\_\_\_

\_\_\_\_\_ for the purpose of my optimal health care.”

**Patient initials:** \_\_\_\_\_

**10. Release of Information to my psychotherapist, psychologist, or other mental health care professional:**

“I hereby authorize Thomas L. Firnberg II, M.D., to release information about my psychiatric treatment to my psychotherapist, psychologist, or other mental health care professional (name, address, telephone, & fax): \_\_\_\_\_

\_\_\_\_\_ for the purpose of my optimal health care.”

**Patient initials:** \_\_\_\_\_

**I understand and agree to all of the above information.**

\_\_\_\_\_  
patient (or guardian) signature

\_\_\_\_\_  
patient (or guardian) name (print)

\_\_\_\_\_  
date