______________ (Clinician)

Psychological Services for Families

410 North A Street, Oxnard, CA 93030
Phone: 805-487-2244, Fax: 487-2255

TODAY'S DATE ______ Client's Name ____________________ Referred By ____________
Age ___ Date of Birth ____________ SS# ____________________ Marital Status: S M D W
Street Address ____________________ City ____________ ZIP ________
Home phone ____________ Cell ____________ Email ____________
Primary Care M.D. ____________________ Phone ____________
Name of Client's Employer ____________________ Phone # ____________

PLEASE THOROUGHLY COMPLETE THIS SECTION:

Responsible Person's Name ____________________ Date of Birth ____________
Relationship to Patient ____________ Occupation ____________________
Spouse Information: Name ____________________ Date of Birth ____________
Phone number ____________ Employer ____________________

PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPYING

Health Insurance Company ____________________
Insured's SS # ____________________ *(If other than Client)* Insured's Date of Birth ____________ *(If other than Client)*

Other Family Members

Child(ren) Name(s) Age Date of Birth School

Others Living in Household ____________________

CURRENT PROBLEM ____________________

Have you had psychotherapy or been treated for emotional/psychological problems in the past?
(Date, Type of Problem) ____________________

Describe any **current** **medical** or **health** problem(s): ____________________

Are you currently taking any medications? Y N

Medication Name Dosage Frequency Length of time

Current use of cigarettes, alcohol, drugs: ____________________

AUTHORIZATION TO PAY

I/We ____________________ do hereby authorize ____________________ to pay directly to Psychological Services for Families medical benefits otherwise payable to me for mental health services. I understand that I am financially responsible for charges not paid by my insurance company.

Date: ____________ Signed: ____________________

RELEASE OF MEDICAL INFORMATION

I/We, hereby authorize Psychological Services for Families to release to my insurance company and/or EAP any information acquired in the course of my treatment.

Date: ____________ Signed: ____________________