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 # ________________

Emergency Contact Information
Name ________________________________ Phone _____________________
Address ____

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 # ____ Insured's Date of Birth _________________*(If other than Client)*
(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 Counseling Services for Family and Children 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 Counseling Services for Family and Children to release to my insurance company and/or EAP any information acquired in the course of my treatment.
Date: ___________________ Signed: ____