



Psychological Services for Families

CLIENT INTAKE

For adult, minor, couple, and family services | Effective date: September 1, 2026

Please complete all sections that apply. Your clinician will review the consent sections with you and answer questions before treatment begins.

CLIENT REGISTRATION

Legal name

Preferred name

Date of birth

Pronouns, optional

Street address

City, state, ZIP

Mobile phone

Other phone

Email address

Occupation or employer

Referral source

Contact preferences

☐ May leave a voicemail with limited information

☐ May send appointment reminders by text

☐ May send administrative messages by email

Preferred contact method

Emergency contact

Name

Relationship

Phone

☐ I authorize contact only when reasonably necessary for safety or an emergency, subject to applicable law.

REGISTRATION AND INSURANCE

Parent, guardian, or responsible party

Name

Relationship to client

Date of birth

Address if different

Phone

Email

Insurance

Health plan

Member ID

Group number

Subscriber name

Subscriber date of birth

Relationship to client

Secondary plan, if any

☐

I authorize the practice to submit claims and receive payment for covered services.

☐

I understand that benefit verification is not a guarantee of payment and that I am responsible for amounts permitted by law and applicable contracts.

Primary care and medications

Primary care clinician and phone

Current medications and doses

Allergies or important medical conditions

CLINICAL HISTORY AND CURRENT CONCERNS

What brings you to therapy now?

What would you like to be different as a result of therapy?

Current symptoms, stressors, or recent major changes

Prior counseling, psychiatric care, hospitalization, or diagnoses

Current and prior psychiatric medications

Alcohol, cannabis, nicotine, and other substance use

Medical conditions, pain, sleep concerns, or health changes

History of trauma, abuse, neglect, or significant loss, optional

Current living situation and people in the household

Cultural, spiritual, identity, accessibility, or language considerations

Current legal, custody, school, work, or military concerns

Immediate safety

- ☐ Current thoughts of suicide or self harm
- ☐ Current thoughts of harming another person
- ☐ Current abuse, violence, stalking, or unsafe living conditions
- ☐ None of the above

If any safety item is checked, please tell staff or your clinician immediately. This form is not monitored continuously.

INFORMED CONSENT FOR PSYCHOTHERAPY

Services

Psychotherapy is a collaborative process intended to support emotional health, relationships, functioning, and personal goals. Services may include assessment, diagnosis when appropriate, treatment planning, individual therapy, couple or family therapy, group services, consultation, and coordination of care.

Benefits, risks, and alternatives

Potential benefits include improved coping, insight, communication, functioning, and symptom relief. Therapy may also involve uncomfortable emotions, difficult memories, temporary distress, relationship changes, or lack of improvement. No result can be promised. Alternatives may include another clinician, medication evaluation, support groups, community resources, a higher level of care, or choosing not to continue.

Participation and ending services

You may ask questions, decline an intervention, request a referral or second opinion, or end treatment. The clinician may recommend another service or end treatment when care is no longer appropriate, attendance or payment issues prevent effective work, needed expertise is unavailable, or safety requires another level of care. Transition options will be discussed when feasible.

Provider and supervision

Services may be provided by appropriately licensed or registered professionals. Registered associates practice under supervision. Specific provider and supervisor information appears in the Notice to Clients section.

Records

The practice maintains clinical and billing records as required by law. Records may include diagnoses, treatment plans, progress notes, communications, screenings, and payment information. Separately maintained psychotherapy notes receive additional protection. Access may be limited when permitted by law.

☐ I consent to psychotherapy and understand that I may ask questions, decline an intervention, or end services.

OFFICE POLICIES AND CONFIDENTIALITY

Confidentiality and its limits

Information is confidential except when you authorize disclosure or when disclosure is permitted or required by law. Examples may include suspected child abuse or neglect, suspected elder or dependent adult abuse, a serious safety threat, certain court orders or legal proceedings, health oversight, and treatment or payment activities allowed by law. The Notice of Privacy Practices explains additional uses, disclosures, and rights.

Emergencies

The practice does not provide continuous crisis coverage. For immediate danger, call 911 or go to the nearest emergency department. For suicide or mental health crisis support, call or text 988. Do not use messages, email, text, or the client portal for urgent needs.

Appointments and cancellations

Provide at least 48 hours notice before the scheduled start time to cancel or reschedule. A \$120 fee may be charged for a missed appointment or cancellation with less than 48 hours notice. Insurance generally does not pay this fee. Exceptions may be made at the practice's discretion. Repeated missed appointments may result in scheduling limits or discharge after clinically appropriate notice.

Fees, insurance, and estimates

Fees and expected client responsibility are provided separately and may vary by clinician, service, and payer contract. Benefit verification is not a guarantee of payment. Clients are responsible for amounts permitted by law and applicable contracts. Uninsured or self pay clients may request and, when required, receive a Good Faith Estimate.

Communication and recording

Electronic communication carries privacy risks and is not guaranteed to be delivered or answered immediately. Administrative email or text should contain minimal clinical information. Recording a session by any participant requires advance permission from everyone involved.

Use of artificial intelligence

Psychological Services for Families may use approved, secure artificial intelligence tools for clinical documentation, record organization, screening, progress tracking, scheduling, billing, referrals, and administrative support. An AI scribe may be used to transcribe psychotherapy sessions and prepare summaries or draft clinical notes. The clinician reviews AI output and remains responsible for clinical decisions and the final record. Protected health information will be used only through approved services and appropriate privacy agreements.

Before an AI scribe is activated, the clinician will explain its use and obtain and document permission from every participant. The AI scribe will not be used if any participant declines. Please inform your clinician if you would prefer that AI not be used. You may decline now or later without losing access to psychotherapy services.

TELEHEALTH, MINORS, COUPLES, AND FAMILIES

Telehealth

Telehealth uses audio and video technology when the clinician and client are in different locations. Benefits include convenience and continuity. Risks include technology failure, privacy limitations, misunderstandings, and reduced access to nonverbal information. When telehealth begins, the clinician will obtain consent, provide the clinician's license or registration type and number, discuss risks and limitations, and identify relevant emergency resources near the client. At the beginning of every telehealth session, the clinician will obtain and document the client's full name and present location and assess whether telehealth remains appropriate. Do not participate while driving. Services are limited to locations where the clinician is legally permitted to practice.

Minors

For a minor, the clinician will discuss consent authority, record access, parent participation, and the privacy the minor can expect. Parents and guardians agree not to use therapy to pressure a child to take sides in custody or family disputes. General treatment information and safety concerns may be shared to the extent permitted by law and clinically appropriate.

☐

I have legal authority to consent to treatment and will provide applicable custody, guardianship, or court orders.

Couple and family services

The relationship or family system may be the treatment focus. Information shared individually may be used in joint work when clinically significant. The clinician will avoid holding information that makes joint treatment misleading or unsafe. Records may contain information about multiple participants. Therapy is not a custody evaluation, forensic evaluation, or agreement to serve as a legal advocate.

☐

I consent to telehealth when clinically appropriate.

NOTICES, ACKNOWLEDGEMENTS, AND SIGNATURES

Required BBS notices, the clinician must mark the applicable notice

☐ Marriage and family therapy

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

☐ Clinical social work

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of clinical social workers. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

☐ Professional clinical counseling

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Board of Psychology notice

NOTICE TO CONSUMERS: The Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. Contact the board at bopmail@dca.ca.gov, www.psychology.ca.gov, 1-866-503-3221, or Board of Psychology, 1625 North Market Boulevard, Suite N-215, Sacramento, CA 95834.

Provider information

Full legal name

License or registration type

License or registration number

Expiration date

Supervisor and license number, if applicable

Acknowledgements

☐ The complete Notice of Privacy Practices was provided or offered, and I may request another copy.

☐ I received the policies, telehealth information, and required professional notices.

☐ I read this consent, had an opportunity to ask questions, and consent to treatment.

Client signature

Parent, guardian, or authorized representative signature

Printed name, relationship, and legal authority

Date

Clinician signature and date

SECURE CARD ON FILE AUTHORIZATION

For security, do not email this completed form. If you choose to provide complete card information on this form, return it directly to the office or through an approved secure method.

Cardholder and card information

Cardholder name _____

Relationship to client _____

Billing address _____

City, state, ZIP _____

Phone _____

Email _____

Card number _____

Expiration date _____ Security code (CVV) _____

Card type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Authorization

I authorize Psychological Services for Families to keep the payment card I provide on file and charge amounts that are my responsibility, including copayments, coinsurance, deductibles, session fees, self pay services, permitted balances after insurance processing, and applicable late cancellation or no show fees in accordance with the practice's financial and cancellation policies. I understand that this authorization remains in effect until I revoke it in writing. Revocation applies only to future charges and does not affect charges already incurred or processed.

Cardholder signature _____

Printed name _____

Date _____

Client name, if different _____

AUTHORIZATION TO RELEASE INFORMATION

For a PCP, school, attorney, family member, or another provider

Client name

Date of birth

I authorize the exchange of information with:

Person or organization

Address

Phone

Fax

Email

Authorized direction:

☐

Disclose to

☐

Obtain from

☐

Both

Purpose:

☐

Care coordination

☐

Insurance or payment

☐

Legal

☐

School

☐

Personal

☐

Other

Information authorized:

☐

Assessment or diagnosis

☐

Treatment plan or progress summary

☐

Attendance and dates

☐

Medication or medical information

☐

Billing

☐

Entire record, except items below

☐

Other

This authorization does not include psychotherapy notes or specially protected information concerning substance use disorder treatment, HIV, genetic testing, or other information requiring specific authorization, unless authorized separately.

Expiration:

☐

One year after signing

☐

Date or event:

I understand that this authorization is voluntary. Psychological Services for Families will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign, except when permitted by law. I may revoke this authorization by sending a written request to 410 N. A Street, Oxnard, CA 93030, or info@psforhelp.org, except to the extent action has already been taken. The recipient may redisclose the information, and it may no longer be protected by federal privacy law. I will receive a copy of the signed authorization.

Client or legal representative signature

Representative name, relationship, and legal authority

Date

Staff or witness signature

PHQ 9, DEPRESSION QUESTIONNAIRE

Over the last 2 weeks, indicate how often each problem has bothered you.

Name

Date

Problem	Not at all	Several days	More than half	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that others could have noticed, or the opposite, being unusually restless	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

Total score:

If you checked any problem, how difficult did it make working, caring for things at home, or getting along with others?

☐ Not difficult
 ☐ Somewhat difficult
 ☐ Very difficult
 ☐ Extremely difficult

If item 9 is anything other than "Not at all," tell staff or your clinician immediately. This form is not monitored continuously.

GAD 7, ANXIETY QUESTIONNAIRE

Over the last 2 weeks, indicate how often each problem has bothered you.

Name

Date

Problem	Not at all	Several days	More than half	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐

Total score:

If you checked any problem, how difficult did it make working, caring for things at home, or getting along with others?

- ☐ Not difficult
 ☐ Somewhat difficult
 ☐ Very difficult
 ☐ Extremely difficult

CURRENT MEDICATIONS

List all medications you currently take, including prescriptions, over the counter medicines, vitamins, and supplements. Attach an additional list if needed.

Client name

Date

☐ I am not currently taking any medications.

Medication name	Dose	How often taken	Reason for taking	Prescribing clinician

Medication allergies or reactions