Hutchinson & Associates

CLIENT REGISTRATION

222 W. Gregory, Suite 100 Kansas City, Missouri 64114 (816) 361-0664

PLEASE PRINT OR WRITE CLEARLY. *Out receptionist will be happy to help you if you have any questions*

CLIENT INFORMATION

DATE: _____

LAST NAME: _____ **FIRST NAME:** _____ **M.I.:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ MOBILE PHONE: ( ) _____

SEX (M/F): _____ DATE OF BIRTH: _____ SOCIAL SECURITY NO: _____

REFERRED BY: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RESPONSIBLE PERSON INFORMATION *(if other than client)*

RELATIONSHIP: _____

LAST NAME: _____ **FIRST NAME:** _____ **M.I.:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ MOBILE PHONE: ( ) _____

SEX (M/F): _____ DATE OF BIRTH: _____ SOCIAL SECURITY NO: _____

EMPLOYER INFORMATION

EMPLOYER: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____

EMERGENCY INFORMATION *(Please provide name of nearest relative not living with you.)*

NAME: _____ TELEPHONE: ( ) _____

IF YOU HAVE INSURANCE COVERAGE
PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE: _____

ATTENTION: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ CLIENT I.D. NO.: _____

GROUP NAME OR NO.: _____ EMPLOYER INSURANCE PLAN (Y/N): _____

POLICY HOLDER NAME *(if other than client):* _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURED PARTY ID NO.: _____ SEX (M/F): _____ BIRTH DATE: _____

RELATION TO CLIENT: _____

NAME OF SECONDARY INSURANCE: _____

ATTENTION: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ CLIENT I.D. NO.: _____

GROUP NAME OR NO.: _____ EMPLOYER INSURANCE PLAN (Y/N): _____

POLICY HOLDER NAME *(if other than client):* _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURED PARTY ID NO.: _____ SEX (M/F): _____ BIRTH DATE: _____

RELATION TO CLIENT: _____

PLEASE READ AND SIGN THE FOLLOWING. IF YOU CHOOSE NOT TO ASSIGN PAYMENT OF BENEFITS DIRECTLY TO HUTCHINSON & ASSOCIATES, PAYMENT IN FULL WILL BE REQUIRED AT TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Hutchinson & Associates. I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the insurance claim form.

SIGNATURE: _____ **DATE:** _____

(Client or Financially Responsible Person)

FOR OFFICE USE ONLY

THERAPIST: _____ **DX:** _____ **ACCT NO.** _____

ATTACH A COPY OF ALL INSURANCE CARDS