HUTCHINSON & ASSOCIATES **CLIENT REGISTRATION**

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

For Office Use Only

THERAPIST: ______________________ CHART NO: __________

CLIENT INFORMATION

DATE: ______________

Last Name: ______________ First Name: ______________ M.I. ______

Address: ______________ Apt# ______

City: ______________ State: ______________ Zip: ______

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Sex (M/F): ______ Date of Birth: ______________ Social Security No: ______________

Email: ______________

Referred by: ______________ Phone: ______________

Address, City, St, Zip: ______________

Referral Source's Email/Website: ______________

RESPONSIBLE PARTY INFORMATION (if other than client)

RELATIONSHIP: ______________

Last Name: ______________ First Name: ______________ M.I. ______

Address: ______________ Apt# ______

City: ______________ State: ______________ Zip: ______

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Sex (M/F): ______ Date of Birth: ______________ Social Security No: ______________

EMPLOYER INFORMATION

Employer: ______________ Occupation: ______________

Address: ______________

Phone: ______________ Website: ______________

EMERGENCY INFORMATION

Name: ______________ Phone: ______________ Cell: ______________

Relationship: ______________

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

INSURANCE INFORMATION

We will need a copy of both sides of your insurance card(s) and picture ID

PRIMARY INSURANCE: ______________________________

Insured ID/Policy No: ______________________ Group No: ______________________

Phone: ______________________ Employer Plan (Y/N): ________ Plan Group Name: ______________________

Policy Holder Name (*if other than client*): ______________________________

Relationship to Client: ______________________ Sex (M/F): ________ Birth Date: ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Website: ______________________________

Email: ______________________________

SECONDARY INSURANCE: ______________________________

Insured ID/Policy No: ______________________ Group No: ______________________

Phone: ______________________ Employer Plan (Y/N): ________ Plan Group Name: ______________________

Policy Holder Name (*if other than client*): ______________________________

Relationship to Client: ______________________ Sex (M/F): ________ Birth Date: ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Website: ______________________________

Email: ______________________________

PLEASE READ AND SIGN THE FOLLOWING (If you choose *not* to assign payment of benefits directly to Hutchinson & Associates, LLC., payment in full will be required at the 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, LLC. 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: ______________________ CHART NO: ________