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: _____ Given Name: _____ M.I. _____

Preferred Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Mobile Phone (if different): _____

Date of Birth: _____ Sex: _____ Social Security No: _____

Gender: _____ Pronouns: _____

RESPONSIBLE PARTY INFORMATION (if other than client)

RELATIONSHIP: _____

Last Name: _____ First Name: _____ M.I. _____

Address *(if different from above)*: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Date of Birth: _____

Email: _____

EMPLOYER INFORMATION (H&A will not contact)

Employer: _____

Location: _____ Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

Relationship: _____

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

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INSURANCE INFORMATION

We will need a copy of your photo ID and BOTH SIDES of your insurance card(s)

PRIMARY INSURANCE: _____

Member No: _____ Group No: _____

Policy Holder Name (*if other than client or responsible party*): _____

Relationship to Client: _____ Sex: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

SECONDARY INSURANCE: _____

Member No: _____ Group No: _____

Policy Holder Name (*if other than client or responsible party*): _____

Relationship to Client: _____ Sex: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

RELEASE OF BENEFITS

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 my claims.

I authorize payment of medical benefits to Hutchinson & Associates, LLC.

I 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)

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CONSENT FOR TREATMENT

Your signature below indicates that you have been provided access to the Patient Service Agreement and agree to its terms and consent to the provision of Psychological Services for yourself and/or dependent named below. It also serves as an acknowledgement that you have received or been apprised of how to secure the HIPAA notice form.

CLIENT NAME (Please Print) SIGNATURE *(PARENT/GUARDIAN if patient is a minor)*

DATE RELATIONSHIP TO CLIENT

CONSENT FOR CONTACT

Your office or its associates may contact me for appointment reminders using:

Home Phone _____ Cell Phone/Text _____ Email _____

Your office or its associates may contact me to conduct the business aspects of my therapy using:

Home Phone _____ Cell Phone/Text _____ Email _____

Your office or its associates may send monthly billing statements to the responsible party using:

Email _____ US Mail _____

SIGNATURE *(PARENT/GUARDIAN if patient is a minor)* DATE

FINANCIAL COMMITMENT

The following guidelines have been established for payment of financial obligations for services rendered in this office. Please read carefully and select the payment arrangement most suitable for your situation. Your signature is required to assure there is no misunderstanding regarding your financial obligation.

[ ] **SELF PAY** No insurance.

[ ] **INSURANCE** Patient copayment is due at the time of service. Any charges not paid by insurance, for any reason, will be transferred to your responsibility and must be paid within 45 days from the date of service.

PLEASE NOTE: There is a *$75.00 per hour* charge for processing FMLA and/or short-term disability paperwork that is not billable to insurance.

I have read the above agreement and understand my financial obligation to this office.

SIGNATURE *(PARENT/GUARDIAN if patient is a minor)* DATE

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INFORMATION AND INFORMED CONSENT FOR TELEHEALTH TREATMENT

Telehealth is live, two-way audio and/or video electronic communication that allows therapists and clients to meet outside of a physical office setting.

CLIENT UNDERSTANDING

I understand that telehealth services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telehealth sessions will be recorded or photographed by the therapist, and I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100% guaranteed to be secure and there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties and agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties and that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telehealth session, my therapist may call emergency services and/or my emergency contact.

I understand that this form is signed in addition to the Patient Service Agreement and Consent for Treatment, and that all office policies and procedures apply to telehealth services.

I understand my therapist will advise me about what telehealth platform will be used and will establish an audio and/or video session.

CLIENT NAME (Please Print) SIGNATURE *(PARENT/GUARDIAN if patient is a minor)*

DATE RELATIONSHIP TO CLIENT

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Client Personal Data Survey

Name: _____ Date: _____

Occupation: _____ Education: _____

Current School and Grade *(for minor clients)*: _____

Current Living Situation: _____

Marital/Partner Status: _____

Spouse/Partner Name *(if applicable)*: _____ Age: _____

Occupation: _____ Employer *(H&A will not contact)*: _____

CHILDREN	AGE	SEX	SIBLINGS	AGE	SEX

What prompted you to call at this time? _____

Previous Therapist(s). *Please list therapist(s) and approximate date(s).*

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Please reach the following list. If you have a HISTORY of any of these symptoms, mark "HX." Mark the symptoms you are PRESENTLY experiencing as "PR."

_____ HIGH BLOOD PRESSURE
_____ LOW BLOOD PRESSURE
_____ HYPOTHYROIDISM
_____ DIZZINESS OR FAINTING
_____ MIGRAINE HEADACHE
_____ TENSION HEADACHE
_____ ALCOHOL MISUSE
_____ DRUG MISUSE
_____ UNSTABLE JOB PATTERN
_____ SUICIDAL THOUGHTS
_____ FEARFULNESS
_____ MOODINESS
_____ UPLEASANT IDEAS STAY IN HEAD
_____ SUICIDE ATTEMPT

_____ JOB UNHAPPINESS
_____ HEAD INJURY
_____ DIABETES or HYPOGLYCEMIA
_____ COLITIS
_____ ULCERS
_____ POUNDING HEART
_____ MUSCLE TENSION
_____ WEIGHT PROBLEMS
_____ HEART TROUBLE
_____ COLD HANDS/FEET
_____ PANIC EASILY
_____ ANXIETY
_____ FATIGUE
_____ CHEST PAIN

_____ DECREASED OR INCREASED APPETITE
_____ INDIGESTION
_____ MEMORY PROBLEMS
_____ NUMBNESS
_____ NIGHTMARES/TROUBLE SLEEPING
_____ DEPRESSION
_____ GUILT
_____ LOW ENERGY
_____ FEELINGS of INADEQUACY
_____ BLACKOUTS
_____ PHOBIA(S)
_____ OTHER _____
_____

MEDICAL INFORMATION

Are you currently being treated for any medical conditions? [ ] YES [ ] NO

If yes, what condition(s)? _____

_____

_____

If you are taking *any* medications, or if you have taken medications recently, including over-the-counter medication for insomnia, etc., please list below.

Rx _____ Rx _____ Rx _____

Rx _____ Rx _____ Rx _____

PHYSICIANS NAME(S)

Dr. _____ Phone (_____) _____

Dr. _____ Phone (_____) _____

Dr. _____ Phone (_____) _____

HOSPITALIZATION(S)

Please list reasons and approximates dates of any hospitalization(s).

_____

_____

_____

CLIENT CONCERNS

Please check the items you would like to address in therapy

CAREER/WORK

__ Career choice
__ Financial concerns
__ Difficulties at work
__ Problems making decisions
__ Personality conflicts
__ Overwork/stress
__ *Other*:_____
__

HEALTH CONCERNS

__ Weight change
__ Eating pattern disorder
__ Tired all the time
__ Concerns about drugs*
__ Bingeing
__ Difficulty sleeping
__ Headaches
__ Concerns about alcohol*
__ Purging
__ Lack of energy
__ Dizziness
__ Nightmares
__ *Other*:_____

PERSONAL CONCERNS

__ Suicidal thoughts
__ Anxious
__ Unhappy
__ No self-confidence
__ Feeling anger
__ Dealing with loss
__ Trouble concentrating
__ Feeling panicky
__ Sensitive
__ Worried
__ Not feeling at all
__ *Other:*_____
__ Depressed
__ Feeling inferior
__ Feelings easily hurt
__ Fearful
__ Dealing with death

SOCIAL RELATIONSHIPS

__ Shy with people
__ Difficulty making friends
__ *Other:*_____
__ Problems maintaining a relationship
__ Feeling lonely
__ Difficulty relating to people
__ Fighting in personal relationships

FAMILY RELATIONS/SPOUSE

__ Sexual concerns
__ Verbal abuse
__ *Other:*_____
__ Marital/partner concerns
__ Physical abuse
__ Fighting
__ Financial stress

FAMILY RELATIONS/CHILDREN

__ Behavior problems at
[ ] Home [ ] School
__ Academic problems
__ *Other:*_____
__ Health Problems
__ Drug or alcohol misuse
__ Survivor of Abuse

FAMILY RELATIONS/PARENTS

__ Care-giver stress
__ Conflict over child raising
__ *Other:*_____
__ Financial concerns
__ Impending loss of loved one
__ Fighting

PERSONAL GOALS

__ Develop assertiveness skills
__ Develop clearer personal identity
__ *Other:*_____
__ Develop more realistic self-expectations
__ Increase awareness of emotional response
__ Accept personal limitations
__ Develop coping skills
__ Clarify personal goals and values

*If checked, please complete reverse side

CLIENT CONCERNS (cont)

Please complete if concerns include drugs and/or alcohol

	AGE at first use	DATE of last use	How often do you currently use this substance, or did you in the past?
Alcohol			
Cannabis			
Psychedelics			
Cocaine/Crack			
Amphetamines			
Tobacco			
Sedative/ Hypnotics			
Opiods			
Benzodiazepines			
Other			