

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: _____

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

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

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

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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	_____ JOB UNHAPPINESS	_____ DECREASED OR INCREASED
_____ LOW BLOOD PRESSURE	_____ HEAD INJURY	_____ APPETITE
_____ HYPOTHYROIDISM	_____ DIABETES or HYPOGLYCEMIA	_____ INDIGESTION
_____ DIZZINESS OR FAINTING	_____ COLITIS	_____ MEMORY PROBLEMS
_____ MIGRAINE HEADACHE	_____ ULCERS	_____ NUMBNESS
_____ TENSION HEADACHE	_____ POUNDING HEART	_____ NIGHTMARES/TROUBLE
_____ ALCOHOL MISUSE	_____ MUSCLE TENSION	_____ SLEEPING
_____ DRUG MISUSE	_____ WEIGHT PROBLEMS	_____ DEPRESSION
_____ UNSTABLE JOB PATTERN	_____ HEART TROUBLE	_____ GUILT
_____ SUICIDAL THOUGHTS	_____ COLD HANDS/FEET	_____ LOW ENERGY
_____ FEARFULNESS	_____ PANIC EASILY	_____ FEELINGS of INADEQUACY
_____ MOODINESS	_____ ANXIETY	_____ BLACKOUTS
_____ UPLEASANT IDEAS STAY IN	_____ FATIGUE	_____ PHOBIA(S)
_____ HEAD	_____ CHEST PAIN	_____ OTHER _____
_____ SUICIDE ATTEMPT		_____

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 | ☐ Difficulties at work | ☐ Personality conflicts |
| ☐ Financial concerns | ☐ Problems making decisions | ☐ Overwork/stress |
| ☐ Other: _____ | | |

HEALTH CONCERNS

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

PERSONAL CONCERNS

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

SOCIAL RELATIONSHIPS

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

FAMILY RELATIONS/SPOUSE

- | | | |
|--|---|---|
| ☐ Sexual concerns | ☐ Marital/partner concerns | ☐ Fighting |
| ☐ Verbal abuse | ☐ Physical abuse | ☐ Financial stress |
| ☐ Other: _____ | | |

FAMILY RELATIONS/CHILDREN

- | | | |
|--|--|--|
| ☐ Behavior problems at
☐ Home ☐ School | ☐ Health Problems | ☐ Survivor of Abuse |
| ☐ Academic problems | ☐ Drug or alcohol misuse* | |
| ☐ Other: _____ | | |

FAMILY RELATIONS/PARENTS

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

PERSONAL GOALS

- | | | |
|--|---|--|
| ☐ Develop assertiveness skills | ☐ Develop more realistic self-expectations | ☐ Accept personal limitations |
| ☐ Develop clearer personal identity | ☐ Increase awareness of emotional response | ☐ Develop coping skills |
| ☐ Other: _____ | | ☐ 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 <u>first use</u>	DATE of <u>last use</u>	How often do you currently use this substance, or did you in the past?
Alcohol	_____	_____	_____
Cannabis	_____	_____	_____
Psychedelics	_____	_____	_____
Cocaine/Crack	_____	_____	_____
Amphetamines	_____	_____	_____
Tobacco	_____	_____	_____
Sedative/ Hypnotics	_____	_____	_____
Opioids	_____	_____	_____
Benzodiazepines	_____	_____	_____
Other	_____	_____	_____