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 (if comfortable): ______________________ Pronouns (if comfortable): ______________________

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)

HUTCHINSON & ASSOCIATES **CLIENT REGISTRATION**

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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 _______

☐ By checking this box you agree to receive recurring text messages from Hutchinson and Associates, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

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

HUTCHINSON & ASSOCIATES

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
_______ 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
__*Other*:________________________
__
__ Difficulties at work
__ Problems making decisions
__ Personality conflicts
__ Overwork/stress

HEALTH CONCERNS

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

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	______________	______________	____________________________________