Akiko Kinney MA MM LMHC
P.O.Box 1394
Bellevue, WA 98009

CLIENT REGISTRATION

GENERAL INFORMATION:

Name:_____ DOB:_____

Mailing Address:_____

City, State, Zip:_____

Best phone number to reach:_____

Best Email address to reach:_____

Emergency contact person:_____

Emergency contact person's phone number:_____

HEALTH INSURANCE INFORMATION

Primary Insurance Company:_____

Insurance ID:_____

Subscriber on Policy:_____

Subscriber ID:_____ Subscriber Birth Date:_____

ASSINGMENT OF BENEFITS: I hereby assign to Soundscape Studios, Akiko Kinney LMHC, my right to the insurance benefits that may be payable to me for the services provided, in my name or in my behalf. I further authorize those payments to be made directly to Soundscape Studios, Akiko Kinney LMHC. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for counseling services. The counselor may release all or part of my medical record to the insurance company required for processing any claims.

Client's signature

Signature:_____ Date_____