George T. Lynn, M.A., M.P.A., L.M.H.C.
Office Address: 1601 116th Avenue N.E., Suite 104, Bellevue, WA 98004
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Counselor Disclosure Statement with Client Agreement
George Lynn, M.A., M.P.A., L.M.H.C.

State Required Disclosure Statement

Counselors practicing for a fee must be licensed with the Washington State Department of Health for the protection of the public health and safety. Licensure with the Department does not include recognition of any practice standard, nor necessarily imply the effectiveness of any treatment.

Required Right to Choose Counselors Statement

You have the right to choose counselors who best suit your needs and purposes. I am Licensed in the State of Washington at the Master's Degree level and do complete continued education requirements for my level of licensure.

License Number of Practitioner: George T. Lynn: LH00005847 NPI Number: 1710004130
Counseling methods and techniques: Cognitive behavioral therapy, stress management consultation, conjoint marital and family therapy, Rogerian Therapy (children)
Course of treatment: Established through periodic evaluation of client desired outcomes and therapeutic process
Counselor background: Please see attached biographical sketch

Telephone Number

Practitioner's telephone number is (425) 454-1787

Fees

In Office Counseling and Consulting

Practitioner bills on the basis of a 50−minute counseling hour. If possible, clients will be notified when this time has expired. If a client wishes to continue the session, additional time will be billed in 15-minute increments based on the following fee structure:

$140.00 for one-to-one counseling
$150.00 for couples or parent-child counseling (two persons)
$160.00 for family counseling
$175.00 for initial intake sessions
$150.00 / hour as a base for pro-rata charges for testing, records evaluation, telephone consultations, and insurance provider administration
$35.00 for email consultation
No fee is charged for appointment scheduling and other logistical matters.

- Payment in full is due at the time of service and is the responsibility of the client not the insurance company. If your insurance plan is paying part of your fee, please pre-authorize your appointment for counseling and bring information that may be used to substantiate your covered benefits and bill your insurance.
- Client accepts responsibility to pay fee for service and acknowledges that therapy may be terminated for non-payment of fee. Client has the right to refuse treatment and will not be billed for services not specifically agreed to with the practitioner.

Cancellation Policy

Cancellations received after 48 hours before a session time (2 *working* days) will be charged $50.00. *Cancellations must be received by telephone*. Please do not send cancellations by email. Cancellations for Monday must be received by Thursday. Cancellations must be received during normal working hours (Monday-Friday, 8:00 a.m. to 5:00 p.m.).

Confidentiality

All transactions between the practitioner and client are confidential. If a breach of confidentiality occurs, clients may file a complaint with the Washington State Department of Health at P.O. Box 47890, Olympia, Washington 98504-7890. 360-236-4030. Exceptions to this Rule include:

- If a client reports abuse or neglect of a child or other vulnerable dependent person
- With a written waiver from a client
- With a waiver provided by bringing charges, complaint, or litigation
- With a subpoena from the Secretary of the Washington State Dept. of Health
- With a discovery request for non-protected information
- If a client tells the practitioner of contemplation or commission of a crime or harmful act
- If necessary to prevent/lessen serious or imminent threat to a person or the public
- If a client reports transmission of life-threatening disease
- If requested by the parent of a dependent child with appropriate Court Order

Client and Counselor Signatures

I have read and understand this disclosure statement and have been provided with a copy of Mr. Lynn's background information and the law pertaining to counselors.

____________________________ ________________________

Client signature   Date

I have given the client a copy of this disclosure statement with attachments indicated above.

____________________________ ________________________

George T. Lynn, M.A., M.P.A., L.M.H.C.   Date