

George T. Lynn, M.A., M.P.A., L.M.H.C.  
Office Address: 1601 116<sup>th</sup> Ave N.E., Suite 104, Bellevue, Washington 98004  
Mailing Address: P.O. Box 3363, Kirkland, Washington 98083  
Phone: (425) 454-1787 Fax: (425) 533-2312 Email: George@georgelynn.com  
www.georgelynn.com

### Client Background Information

This information is kept in the strictest confidence and is used to facilitate counseling services and billing efficiency. Please fill this out, read and sign the attached Agreement, and keep a copy for your records.

Name of client: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's date: \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

For children and teens, name of parent: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (eve) \_\_\_\_\_ email: \_\_\_\_\_

Can leave messages at above numbers or email: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for referral or problem: \_\_\_\_\_

\_\_\_\_\_ Physician: \_\_\_\_\_

Current diagnoses: \_\_\_\_\_

Medications client is taking: \_\_\_\_\_

### **Billing/Insurance Information**

Primary Insurance Plan: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance billing address: \_\_\_\_\_

Policy holder (please identify by name): \_\_\_\_\_ ID number: \_\_\_\_\_

Policy holder's birthdate: \_\_\_\_\_ Policy holder's group number: \_\_\_\_\_

Exclusions in policy (Family counseling, etc): \_\_\_\_\_

Is your deductible satisfied (if applicable)? \_\_\_\_\_. Approximate amount remaining: \_\_\_\_\_.

Secondary Insurance Plan, if applicable: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance billing address: \_\_\_\_\_

Policy holder (please identify by name): \_\_\_\_\_ ID number: \_\_\_\_\_

Policy holder's birthdate: \_\_\_\_\_ Policy holder's group number: \_\_\_\_\_

Exclusions in policy (Family counseling, etc): \_\_\_\_\_

Is your deductible satisfied (if applicable)? \_\_\_\_\_. Approximate amount remaining: \_\_\_\_\_

Thank you!