

**Lynda Lahman, MA, LMFT**

325 118<sup>th</sup> Ave SE, Suite 310 Bellevue, WA 98005 (425)451-3030 fax (425) 283-0443

**Client Information**

Name: \_\_\_\_\_ Client ID # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital/Partner Status \_\_\_\_\_

Client Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Insurance**

Person responsible for account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID # \_\_\_\_\_

Address (if different from client's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person responsible employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**Secondary Insurance**

Person responsible for account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID # \_\_\_\_\_

Address (if different from client's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person responsible employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## **Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and  
Name of Insurance Company(ies)

assign directly to **Lynda Lahman, MA, LMFT** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

**Lynda Lahman, MA, LMFT** may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agencies for the purpose of obtaining payment for services and determining insurance benefits or the benefits paid for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Client, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Client, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Client

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**GENERAL INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Date of Last Physical: \_\_\_\_\_

Medications: \_\_\_\_\_

Current or Chronic Health Problems: \_\_\_\_\_

Previous Counseling or Psychotherapy: \_\_\_\_\_

Why are you coming to therapy at this time? \_\_\_\_\_

Please list the goals you hope to achieve in counseling: \_\_\_\_\_

Is there anything else you think I should know as we begin? \_\_\_\_\_

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## INFORMATION DISCLOSURE

**Therapeutic Relationship:** Psychotherapy is a supportive relationship. It is important that you understand certain aspects of this relationship to better participate in your treatment. Washington state law requires that you be informed of your rights as part of your initial interview.

You have the right to decide whether or not to work with me as your psychotherapist. If you wish, I can provide you with the names of other qualified therapists. You have the right to end therapy at any time without legal or moral obligation. You are responsible for any actions or choices you make during the course of therapy. You have the right at any time to discuss your treatment and my particular therapy methods. Should you have any questions, please do not hesitate to ask.

**Licensure:** Counselors practicing counseling for a fee must be registered or licensed with the Department of Licensing for the protection of public health and safety. Licensure of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. Licensure standards are set by the Department of Licensing of the State of Washington. The purpose of the Counselor Licensing Act is to provide protection for public health and safety and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. Available with this paperwork is a copy of the RCW 18.130.180 list of unprofessional conduct standards.

**Confidentiality:** I am required to report to the appropriate authorities if it appears you are a danger to yourself or someone else, or if I have reasonable cause to suspect abuse of a child, dependent adult, or developmentally disabled person. I may at times consult with other professionals. All consultations will be done in a manner to protect your anonymity.

**Records:** A record of the mental health care provided to you is kept by me. You may ask to see and copy that record. You may also ask me to correct that record, if you believe the information in your record is in error. A copy of your corrections will be placed within your record, at your request. I will not disclose your record to others unless you direct me to do so, or unless the law authorizes or compels me to do so. If you are using insurance, be aware they may obtain your records for determining your claim eligibility. By signing an insurance form, you are authorizing me to release those records should the insurance company request them.

**Emergencies:** If it is urgent that you need to speak with me right away, please call my office (425-451-3030) and leave me a message. I will attempt to return your call as soon as I possibly can. If it is extremely urgent and you are unable to reach me, please call the Crisis Clinic at (206) 461-3222 or (800) 244-5767.

**Background:** I am a licensed Marriage and Family Therapist in the state of Washington. I am a Clinical Member of the American Association for Marriage and Family Therapy. I received my Master of Arts degree in 1978 from Azusa Pacific College. I have had additional training in Hypnotherapy, CISD, Lifespan Integration, and EMDR. I am certified by the Eye Movement Desensitization and Reprocessing International Association in EMDR and by the American Society of Clinical Hypnosis in hypnosis. My experience includes 5 years in residential treatment with children; 2 years as a school counselor; and over 29 years of individual, couple and family therapy in clinic and private practice settings. I utilize ACT & Cognitive Behavioral Therapy, EMDR, Lifespan Integration, hypnosis, reading assignments, and homework exercises, all of which will be discussed with you.

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You are being seen by Lynda Lahman as an independent practitioner. I alone am responsible for my work with you. If you have any questions about the material presented here, or questions which were not answered, please discuss them with me. **Please sign below to indicate that you have read and understand this information, have been shown the State of Washington Department of Licensing booklet (copies for you to take are in the waiting room), and have received a copy of the Unprofessional Conduct Standards.** At your request, I will make a photocopy of this form to take with you.

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Signature

Date

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Therapist

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**FINANCIAL INFORMATION**

Appointments are 50 minutes long and are billed at the rate of \$150 per session. The initial intake session is \$200. Emergency phone sessions are billed at the same rate, in quarter hour segments, after the first 5 minutes. **You are asked to cancel any appointments at least 24 hours in advance. You will be charged the full fee for missed appointments and ½ fee for cancellations with less than 24 hours notice (insurance cannot be billed in either circumstance).** This time had been reserved for you and cannot be given to someone else without sufficient notice.

Payment is due at the beginning of each session unless prior arrangements have been made. You are responsible for your account and are expected to pay for all services you receive. As a courtesy, I will bill your insurance company if I am a provider in their network.

It is important that your account be kept current. If you are unable to pay in a timely manner, we will need to discuss suspending sessions until you are able to resume payments. If you need a referral to another provider I will help facilitate the referral if requested. Any accounts that are past due, with no attempts at payments or responses to requests for payments, will be referred to a collection agency at my discretion. **Please initial here that you give me permission to release your identifying information to a collections agency should I need to take such action \_\_\_\_\_.**

This contract is only with Lynda Lahman who operates as an independent practitioner.

Having read the above contract, I understand my responsibilities for payment. My signature confirms acceptance of the above terms and constitutes informed consent for psychotherapy without exception.

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Signature

Date

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Therapist