Lynn Wunder MA, LMFT
33442 1st Way S. Suite 101
Federal Way, WA 98003
253-545-9129

NEW CLIENT REGISTRATION

Personal Information

Name:_____

Address:_____

City, State, Zip Code:_____

Home Phone:_____okay to leave messages? Yes____ No____

Cell Phone:_____ okay to leave messages? Yes____ No____

Date of Birth:_____ Marital Status: Single Married Divorced Widowed

Employment: Full-time Part-time Not employed Student: Full-time Part-time

Employer:_____ Occupation:_____

In the event of an emergency, who should be contacted?

Name:_____ Relationship:_____ Phone #:_____

Insurance Information

Insurance Company:_____ Policy #:_____

Group #:_____ Effective Date:_____

Insured's Name:_____ DOB:_____ Relationship_____

SS#:_____ Employer:_____

I consent to treatment for above-named individual and I authorize the release of complete information to my insurance carrier , or its intermediaries regarding services here, and assign benefits to provider for services rendered.

FINANCIAL AGREEMENT Please be prepared to fully cover the fees for each visit. If you have insurance, you will be expected to pay the portions of my fees not covered by your insurance. If you do not have insurance, you will be expected to pay my fees at the time of service. I will submit fees to your insurance carrier as a courtesy to you, but it is your responsibility to make sure your insurance carrier has paid for treatment. You are solely responsible for all charges incurred.

CANCELLATION POLICY If you are unable to make your appointment time, please call at least 24 hours in advance to reschedule your appointment. If you do not give 24 hours advance notice, you will be charged a fee for a broken appointment.

All information contained above is complete and accurate to the best of my knowledge. I have read and fully understand this agreement.

Patient Signature:_____ Date:_____

Legal Guardian and/or Insured Signature:_____