Holly Lien, MA, LMFT LICENSE # MFC 35076 1736 Picasso Ave., Suite A, Davis, CA 95618
Holly@HollyLien.com (530) 220-3433 Specializing in Individual & Family Therapy, Adolescents, & Adoption

Client Information Update Form

(for returning clients only)

Name:_____

Address:_____ City:_____ State:_____ Zip: _____

Phone (home):_____ (work):_____ (cell): _____

Email: _____ Age:_____ Date of Birth:_____

Medications

Current medications (name, dosage, & date started): _____

_____

Prescribing doctor (name & phone number):_____

Insurance

(Note: Please disregard this section if you are not billing your insurance or EAP)

Name of subscriber's employer: _____

Name of your insurance company or EAP:_____ Phone:_____

Subscriber's name:_____ Subscriber's date of birth:_____

Subscriber's ID#:_____ Group#:_____

Subscriber's address:_____ City:_____ State: _____ Zip:_____

Authorization No.: _____ Number of sessions covered:_____

Date authorization begins: _____ Ends: _____ Copay amount: _____

Your relationship to the insured (check one): ☐ self ☐ spouse ☐ child ☐ other: _____

I hereby authorize the release of any medical or other information necessary to process medical insurance or EAP claims related to treatment. I authorize direct payment to Holly Lien, LMFT for insurance reimbursement of covered services.

Date:_____ Signature:_____