Frank Hesketh, MA, LMHC
PO Box 11921
Olympia, WA 98508
Work: 360.584.8929
FAX: 360.547.7779
Email: fjhesketh@gmail.com
www.frankhesketh.com

Diagnosis (filled out by office)**:** _____

Note: Please print clearly and complete all of the information so that your claim can be processed quickly and efficiently. All information is required for insurance billing.

CLIENT INSURANCE INFORMATION

CLIENT NAME _____ DATE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME NUMBER _____ CELL NUMBER _____

BIRTHDATE _____ SS # _____

EMPLOYER_____

INSURANCE INFORMATION: (This information is on your insurance card. If you prefer you may send a copy of your card.)

INSURANCE COMPANY NAME _____

INSURANCE CUSTOMER SERVICE NUMBER _____

ID NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ _____

INSURED SS # _____ BIRTHDATE _____

RELATIONSHIP TO CLIENT Self Spouse Dependent Copay: _____ Deductible: _____

SUBSCRIBER EMPLOYER'S NAME _____

Do you have a secondary Insurance? If yes, who? _____

ID # _____ Subscriber Name & Date of Birth _____

I authorize Frank Hesketh to bill my insurance company and to receive payment from my insurance and release information required to process any claims. I understand that I am ultimately responsible for all charges I incur regardless of insurance coverage. While we contact your insurance company regarding your benefits, we advise you to also contact your insurance directly. (Not all benefits quoted are a guarantee of payment).

Client Signature(s)_____ Date_____