Frank Hesketh, MA, LMHC
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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 ____________________________ M___ F___ SS # _________________________

EMPLOYER____

INSURANCE INFORMATION: (this information is on your insurance 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 EMPLOYERS 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/or 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___________________