Steve L. Franks, M.A.
Licensed Marriage and Family Therapist
Individual psychotherapy and couples counseling

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Office (253) 952-0550

INSURANCE INFORMATION

Client: First Name ___________________ M.I. ____ Last Name ______________________

Birth Date _____/_____/______ Gender M ☐ F ☐

Insurance Company Information - Primary Coverage

Insurance Company Name ________________________ Phone Number__________________

Policy Holder ____________________________ Birth Date ____/____/____ Gender M ☐ F ☐
Relationship to Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐

ID # ______________________Group#_____________ Address (policy holder if different from client)

____

Under Employer's Health Plan? Y ☐ N ☐ Employer's Name ________________________
Have you obtained authorization from your insurance? Y ☐ N ☐ If yes, complete the following:

Authorization Date: ______________ Authorization # ____________________________________

Insurance Company Information - Secondary Coverage (complete if have another insurance)

Insurance Company Name______________________ Phone Number _____________

Policy Holder ______________________________ Birth Date ____/____/____ Gender M ☐ F ☐
Relationship to Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐

ID# ______________________ Group # ____________ Address (policy holder if different from client)

____

Under Employer's Health Plan? Y ☐ N ☐ Employer's Name ____________________________
Have you obtained authorization from your insurance? Y ☐ N ☐ If yes, complete the following:

Authorization Date: _____________ Authorization # ____________________________________

Client or Authorized Person's Signature

I authorize Steve L. Franks, M.A., LMFT to release any medical or other information to process this claim or further claims. I authorize payment of medical benefits to Steve L. Franks, M.A., L.M.F.T. LLC

Signed ____ Date ______________________

To be completed by therapist: Referral: None needed __ Physician __ Co-pay ______ Deductible______
Amount Met: ____ # Sessions Authorized ____ # Sessions ____/yr Client % _____ Payment %_______
Authorization: ____None ___ Diagnosis: __________ __________
Approved CPT Codes: ___________________________ Exclusions: __________________________
Policy effective and end date: _______________ Comments: _________________________________