Frank Geis M.A, LPC, LMFT
1901 N. Central Expressway, Suite 220
Richardson, Texas 75080

HEALTH INSURANCE INFORMATION

Client's Name: ________________________________ Client's Date of Birth: _____________

Name of Insured: ______________________________ Insured's Date of Birth: ____________

Client's Relation to Primary Subscriber:

_____Self ____ Spouse ____ Child ___ Other

Name of insurance (mental /behavioral): ____

ID Number of Insured as listed on Insurance Card: _________________________________

Group # (if applicable): _____________________

Address on insurance card: ____

City: ___________________ State: _____________ Zip: _____________

Phone Number on card: ___________________________

I agree and approve to the payment of $5/ per session for the administrative and processing fees associated with the use of payment with a credit card and the filing and collecting of the insurance claims through the insurance company. I understand this charge is separate from and in addition to the agreed co-payment amount and the negotiated per session rate of the insurance plan. Said fee shall be collected in conjunction with the co-payment amount at the time the services are provided by the counselor.

I hereby authorize my insurance benefits to be paid directly to the counselor. I understand that I am financially responsible for any balance of the insurance payment as well as the administrative and processing payment. I also authorize Frank Geis MA, LPC, LMFT, or insurance company to release any information required to process my claims.

____ _________________________
Client /Guardian Signature Date

Please make a copy of your Insurance Card (Front and Back) and a copy of your Driver's License and please attach.