



Don Baker, MA, LMHC

1836 Westlake Avenue North - Suite 303A

Seattle, Washington 98109

support@unpackingadhd.com

www.unpackingadhd.com

Insurance Details

Please provide insurance details or bring a photo or copy of both sides of your insurance card to the first session.

Name of Insurance Provider (Premera, Regence, etc.): _____

Name of Primary Individual Insured: _____

ID Number (be sure to include 3-letter prefix): _____

Group Number: _____

Telephone for Provider: _____

Use of Credit Card Consent

I authorize **Don Baker, MA, LMHC** to keep my signature on file and to charge the credit card selected below for the following:

- Balance remaining after claim (s) is (are) resolved with my insurance company / full session amount if no insurance
- I authorize charges for the following family members:

(authorized family member)

(authorized family member)

I'll be using my:

- Visa
- MasterCard
- American Express
- Discover Card
- Health Savings / Flex Plan

Credit Card Number: _____

Exp. Date: _____

Code on Back of Card: _____

Client Name: _____

Full Name on Card: _____

Cardholder Address: _____

City: _____

State: _____ Zip: _____

Cardholder Signature: _____

Date: _____