**Graceview Counseling Center, PLLC**
25510 Tomball Parkway
Tomball, Texas 77375
713-306-7061
www.graceviewcc.com
graceviewcounselingcenter@gmail.com

## Patient Information

Patient Name: _____ Date of Birth: _____
Street Address: _____

City:_____ State:_____ ZIP:_____

Home Phone: _____ Work Phone: _____

Emergency Contact:_____ Emerg Phone: _____
Sex: □ Female □ Male Age_____ Marital Status: □ Single □ Married □ Partnered □ Divorced □ Separated □ Widowed □ Other Employer

_____
Occupation_____
E-mail Address: _____
Race: □ American Indian or Alaskan Native □ Asian or Pacific Islander □ Black □ White
Ethnicity: □ Hispanic Origin □ Not of Hispanic Origin

## Primary Insurance

Company: _____

Phone: _____

Ins Claims Address: _____

City: _____ State: _____ Zip: _____

Policy/ID #: _____ Group/Plan _#:_____

Policy Holder Information: (if the patient is not the employee/policy holder)
Name:_____

Relationship: _____
Address:_____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Soc. Sec#_____
Employer_____

## Secondary Insurance

Company: _____

Phone: _____

Ins Claims Address: _____

City: _____ State: _____ Zip: _____

Policy/ID #: _____ Group/Plan _#:_____

Policy Holder Information: (if the patient is not the employee/policy holder)
Name:_____

Relationship: _____
Address:_____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Soc. Sec#_____
Employer_____

## Responsible Party

Where should the patient's portion of the bill be sent, if not to the patient?

Name: _____
Relationship: _____
Address:_____
Phone: _____

## Assignment and Release

I, _____, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

_____

Relationship to Patient

Please provide a copy of the front and back of your insurance card.