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.