INSURANCE FORM

PATIENT INFORMATION:

Patient Name: _____
(Last) (First) (Middle Initial)

Home Address: _____ Apt # _____

_____
City State Zip Code

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____ Gender: _____

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partnered

Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full Time Student ☐ Part Time Student

Name of Employer / School: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Member ID Policy #: _____ Group #:_____

Claims Address: _____ Phone #: _____-_____-_____

Policy holder's Name: _____ Date of Birth: _____/_____/_____
Month Day Year

Social Security #: _____ Effective Date of Insurance: _____/_____/_____
Month Day Year

Policy Holder's Employer: _____ Phone #: _____- _____-_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other_____

_____ *Date of Birth:*____/_____/_____ *Phone #* _____-_____-_____

Name (if different from patient) *Month Day Year*

Secondary Insurance (If Applicable): _____

MemberID Policy #: _____ Group #:_____

Policy Holder Name: _____Date of Birth: _____/_____/_____
Month Day Year

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize the Clear View Counseling Center, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____