Phone: 216-252-1399
Fax: 216-252-1409

daily BEHAVIORAL HEALTH

14538 Grapeland Avenue
Cleveland, Ohio 44111

Patient Information

Patients Full Name:		Social Security Number:	
Address: Street		City	State Zip
Phone:	Date of Birth:		Sex:

Responsible Party Information

Responsible Party Name:		Relationship to Patient:	
Address (if different from above): Street		City	State Zip
Phone:		Email Address:(will be used for appointment reminders)	
Sex:	Date of Birth:	Marital Status:	Social Security Number:
Employer:		Work Phone:	

Primary Insurance Information

Name Of Insurance Company:		Employer of Policy Holder:	
Name of Policy Holder:	Date of Birth:	Relationship to Patient:	
Policy Holder Address (if different from above): Street		City	State Zip
Sex:	Phone:	Social Security Number:	
Group Number:		Policy/ID Number:	
Insurance Billing Address: Street City		State Zip	Insurance Phone Number:

Secondary Insurance Information

Name Of Secondary Insurance Company:		Employer of Policy Holder:	
Name of Policy Holder:	Date of Birth:	Relationship to Patient:	
Policy Holder Address (if different from above): Street		City	State Zip
Sex:	Phone:	Social Security Number:	
Group Number:		Policy/ID Number:	
Insurance Billing Address: Street City		State Zip	Insurance Phone Number:

Agreement, Assignment of Benefits, Assumption of Responsibility, and Records Transfer Authorization: I hereby assign to Daily Behavioral Health, Inc. all benefits to which I am entitled from all private and public medical insurance plans including Medicare and Medicaid. I understand that I am financially responsible for all treatment charges for services rendered by Daily Behavioral Health, Inc. regardless of any limitations of insurance coverage, divorce agreements, or victim's assistance. I understand that I will be charged for appointments missed unless 24 hour notice is given to Daily Behavioral Health, Inc. I understand all deductibles and co-payments must be paid in full. Co-payments must be paid to Daily Behavioral Health, Inc. at the time of service. I understand that my coverage is part of a contractual arrangement between Daily Behavioral Health, Inc. and a specific third party payer. Daily Behavioral Health, Inc. agrees to abide by the regulations and reduced rates outlined in those contracts. I hereby agree to the above and hereby authorize Daily Behavioral Health, Inc. to release information about my condition and treatment to those who are part of the process of securing insurance payment for the same. I authorize payment to be made directly to Daily Behavioral Health, Inc. This assignment and authorization will remain in effect until revoked by me in writing. I acknowledge that a photo copy of this assignment and authorization is as valid as the original. **Failure to sign this agreement will require you to pay in full at the time of each visit.**

Signature of Insured / Responsible Party: _____ _____Date: _____

Signature of Patient (Parent/ Guardian if under 18): _____Date: _____