Patient Registration

We are not a Cleveland Clinic or UH provider we also do not accept EAP'S.

Name_____________________________________ ____

Last First

Address____ City_____________________ Zip____________

Phone_______________________DOB__________________Email___________________________________

Parent/Guardian___________________________________ Phone__________________________________

Primary Insurance

Insurance Co.__________________________________ ID#_____________________________________

Group#_________________________ Provider phone # on back of card__________________________

Name of insured____________________________________ Pt relation_____Self_____Spouse_____Child

Secondary Insurance

Insurance Co.________________________________ ID#_______________________________________

Group#__________________________ Provider phone # on back of card__________________________

Name of insured__________________________________ Pt relation_____Self_____Spouse_____Child

Consent for Treatment and Payment: By signing below, I as the patient or legal guardian, authorize consent for treatment by Gabriel Group Counseling. I also consent for the Insurance Carrier to make checks for medical expenses due me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the Insurance Carrier. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers

Signature____ Date__________________________________

The Health Insurance Portability and Accountabilty Act (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential.

Signature____ Date_________________________________