Bracken Psychiatric Services
3200 Southern Dr. #107 Garland, Tx 75043 Ph: (972) 278-5385 Fax: (972) 692-8687
E-mail: admin@brackenmentalhealth.com www.brackenmentalhealth.com

# ADULT
# CHANGE OF INSURANCE

## PATIENT INFORMATION

Patient Name _____ Birth Date_____ Age_____

Street Address _____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email _____

## GUARDIAN INFORMATION IF APPLICABLE

Father/Guardian Name _____ Mother/Guardian Name_____

## INSURANCE INFORMATION

Previous/Old Insurance Co._____ ID# _____

Group# _____ Subscriber Name _____

New Primary Insurance Co._____Phone#_____

ID#_____ Group# _____

Subscriber Name _____DOB____/__/_____Soc. Sec. # _____

Employer_____Emply. Phone_____

New Secondary Insurance Co._____Phone#_____

ID# _____ Group# _____

Subscriber Name _____DOB____/___/_____Soc. Sec. # _____

Employer_____Emply. Phone_____

_____ _____ _____
Patient/Responsible Party/Guardian Name Signature Date

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I hereby authorize Bracken Psychiatric Services to treat the named patient and to release any medical records required by the insurance company in order to process claims. Payment of all services is assigned to Bracken Psychiatric Services. I understand that I am responsible for charges not paid by my insurance carrier within sixty (60) days of services within the limits of my policy and that **payment of co-payment and/or coinsurance is required at the time of service.**

NOTE: Insurance Pre-Authorization: It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services.

By signing below I certify that all information given in the supporting documentation I have provided is true and correct to the best of my knowledge.

Patient Name_____

_____ _____ _____

Responsible Party/Guardian Signature Date

Copy Patient's Insurance Cards and
Responsible Party's valid Texas I.D. Here


**Form will not be processed without it.**