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

CHILD
CHANGE OF INSURANCE

PATIENT INFORMATION

Patient Name _____ Birth Date_____Age_____

Street Address _____

City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email _____

Note: For Medicaid insurance the child is the subscriber.

Previous/Old Insurance Co._____ ID# _____

Subscriber Name _____

New Primary Insurance Co._____Phone#_____

ID# _____ Group# _____

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

Secondary Insurance Co._____Phone#_____

ID# _____ Group# _____

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

Tertiary Insurance Co._____Phone#_____

ID# _____ Group# _____

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

_____ _____ _____

Responsible Party/Guardian Name Signature Date

Relation to Patient_____

Updated 1/19/2014

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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.

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Private Pay Agreement

I understand that Bracken Psychiatric Services is accepting patient name:_____ as a private pay patient for the period of 1 year from today's date and as such I will be responsible for paying at the time of services for any services and fees I receive. I understand that the provider will not file a claim to Medicaid for services provided to the patient. I understand that I may recieve services from another provider at no cost using my Medicaid but I am choosing to pay privately so that the patient may receive services at Bracken Psychiatric Services.

Patient Name:_____ DOB:_____

Guardian Name:_____

Guardian Signature:_____

Date:_____

Note: As of 07.18.2014 we no longer accept Medicaid as a secondary insurance. If you have Medicaid as a secondary insurance you will need to complete this form.