PLEASANT CARE
BEHAVIORAL HEALTH

In order to best serve your medical needs, we ask that you complete the following packet in full before your arrival to our office. Although we do appreciate any efforts to save our environment, we ask that you print out the packet as it is shown to you; single sided and in black ink. When filling out the packet, please use black or blue ink. If you are unable to comply with the fore-mentioned requests, please arrive 40-45 minutes prior to your appointment so that you can complete your paperwork in a timely manner. We appreciate your cooperation with us.

Thank you,
Pleasant Care Behavioral Health Services, Inc.

PLEASANT CARE
BEHAVIORAL HEALTH

REGARDING INSURANCE PLANS

You can be helpful in preserving our ability to provide services to you under your insurance plan by making certain that you track the timely payment of your claim**. If you do not receive an Explanation of Benefits (EOB) from your insurance company within 30 days from the date of your appointment, you should call them to check on the status of your claim**. If you receive an EOB, but it shows that no payment was made to us, you need to call your insurance company.

Unpaid balances beyond 45 days will, by necessity, be charged to your credit card. Hopefully, your efforts and ours will meet with success.

Thank you,

Pleasant Care Behavioral Health Services, Inc.

905 Medical Centre drive,
Arlington Tx 76012
(817) 461-3823

PATIENT INFORMATION

DATE: _____

Patient's Name: _____
(First) (Middle) (Last)

How do you wish to be addressed?_____ Marital Status: _____

Address:_____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ Work Phone: (_____) _____

Birthdate:_____ SS#_____

Employer: _____ Occupation:_____

Years Employed: _____

If Patient is a Minor (under age 18), name of parent or guardians _____

Referred By:_____
(Name) (Relationship)

RESPONSIBLE PARTY

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

Marital Status: _____ Drivers License# _____

Address: _____
(Street) (City) (State) (Zip)

How long at this address? _____ Relationship to Patient: _____

Previous address(if less than 3 years): _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Birthdate:_____ SS#_____

Employer: _____ Years Employed: _____

Occupation:_____

SPOUSE INFORMATION (if applicable)

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

Birthdate:_____ SS#_____

Employer: _____ Years Employed: _____

Occupation:_____

INSURANCE INFORMATION

Primary Insured Policy Holder Name: _____
(First) (Middle) (Last)

Birthdate:_____ SS#_____

Employer: _____ Group #: _____

Insurance Company Name:_____ Member Services Phone #: _____

PLEASANT CARE BEHAVIORAL HEALTH

EMERGENCY INFORMATION

In case of emergency, call: _____

Work Phone: _____

Home Phone: _____

Relationship to patient: _____