san marcos treatment center

120 BERT BROWN ROAD
SAN MARCOS, TX 78666
(512) 396-8500

NOTICE OF ADDITIONAL INSURANCE COVERAGES

Patient Name: _____ **DOB:** _____

Prescription Coverage

Does the patient currently have prescription benefits? ☐ Yes ☐ No
Insurance Company Name _____
Policy Holder Name _____
Type of Coverage ☐ Individual Policy ☐ Group Policy
If Group Policy, Please List Employer _____

Dental Coverage

Does the patient currently have dental insurance? ☐ Yes ☐ No Last Exam _____
Patient will have a dental exam and cleaning if it has been more than one year since last visit.
Insurance Company Name _____
Policy Holder Name _____
Type of Coverage ☐ Individual Policy ☐ Group Policy
If Group Policy, Please List Employer _____

Vision Coverage

Does the patient wear glasses? ☐ Yes ☐ No Last Exam _____
Does the patient currently have vision insurance? ☐ Yes ☐ No
Patient will be examined <u>either</u> if they wear glasses and have not been seen within 1 year <u>or</u> if they fail vision screening.
Insurance Company Name _____
Policy Holder Name _____
Type of Coverage ☐ Individual Policy ☐ Group Policy
If Group Policy, Please List Employer _____

Additional Medical Problems

Does the patient have additional medical problems? ☐ Yes ☐ No
(use back of form if necessary)

List	Medications Taken
_____	_____
_____	_____
_____	_____

*You will be asked to provide these medications during the patient's stay. The facility will order refills from an outside pharmacy if you provide prescription benefit / coverage information.**
**(Note: an EKG is required for prescription of stimulants, antipsychotics and Lithium.)*

_____
Signature