Daughters of Charity Services of Arkansas

Reaching Out With Care

[ ] DePaul Health Center [ ] St. Elizabeth Health Center

Patient / Client Information — Please Print

Name Last First MI

Street Address City State Zip Code County

Home Phone | Work Phone | Cell Phone | Birth Date | Social Security No.

Sex ☐ M ☐ F Marital Status ☐ Single ☐ Married ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Temp ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Student

Employer

Address City State Zip Code

Responsible Party — Name of Person Responsible for Account

Relationship to Patient / Client: ☐ Parent / Guardian ☐ Spouse ☐ Other ☐ Self (if Self, skip to insurance information)

Name Last First MI

Street Address City State Zip Code County

Home Phone | Work Phone | Cell Phone | Birth Date | Social Security No.

Sex ☐ M ☐ F Marital Status ☐ Single ☐ Married ☐ Widowed

Employer

Address City State Zip Code

Insurance Information — Copy of Insurance Card ☐ No Insurance

Insurance Company | Policy Holder | Group Number | Individual ID No.

Assignment and Release:

I authorize my insurance benefits to be paid directly to Daughters of Charity Services of Arkansas. I understand that I may be responsible for non-covered charges. I also authorize DCS-ARK to release any information required to process this claim. I hereby authorize the release of medical information between St. Elizabeth Health Center in Gould and DePaul Health Center in Dumas for _____

Signature _____ Date _____

Consent to Treatment:

I, _____, hereby voluntarily consent to and request ☐ Medical ☐ Dental ☐ Counseling treatment for

☐ Myself ☐ Child or dependent: _____ by the healthcare providers of DCS-ARK.

_____ _____

Signature of Patient / Client or Guardian for a Minor Date

_____ _____

Witness Date