Brian DesRoches, MSC, Ph.D., LMFT
Contact Information, Financial Responsibility and Insurance Forms

Name _____ DOB ___/___/____ Age _____

Preferred Phone _____ __ CellPh __ HmPh __ WkPh __ Other: _____

*Email _____ Preferred Communication __ Cell __ HmPh __ WkPh __ Email

*See Email, Texting and Social Media Privacy Policy

Okay to leave a message on my: __Home __ Cell __ Work number __ Other

Residential Address _____ City _____ Zip _____

May I send mail to this address? __ Yes __ No

Email _____ May I use email to confirm appointments? __ Yes __ No

Employer _____ Type of Work _____

Relationship Status Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact _____Relationship_____Phone_____

Financial Responsibility—*If you will be using insurance benefits, please complete the attached insurance HCFA1500 insurance form and the information below.*

Name of Insured _____Date of Birth ___/_____/____

Insured's Employer _____

Insurance Carrier _____Policy # _____ Group # _____

Insurance Effective Date: _____ Co-pay amount:_____ Have you met your deductible? Y / N

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier.

Assignment of Benefits: I authorize payment of insurance benefits for services rendered to Brian DesRoches, Inc.

Financial Responsibility: I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services.

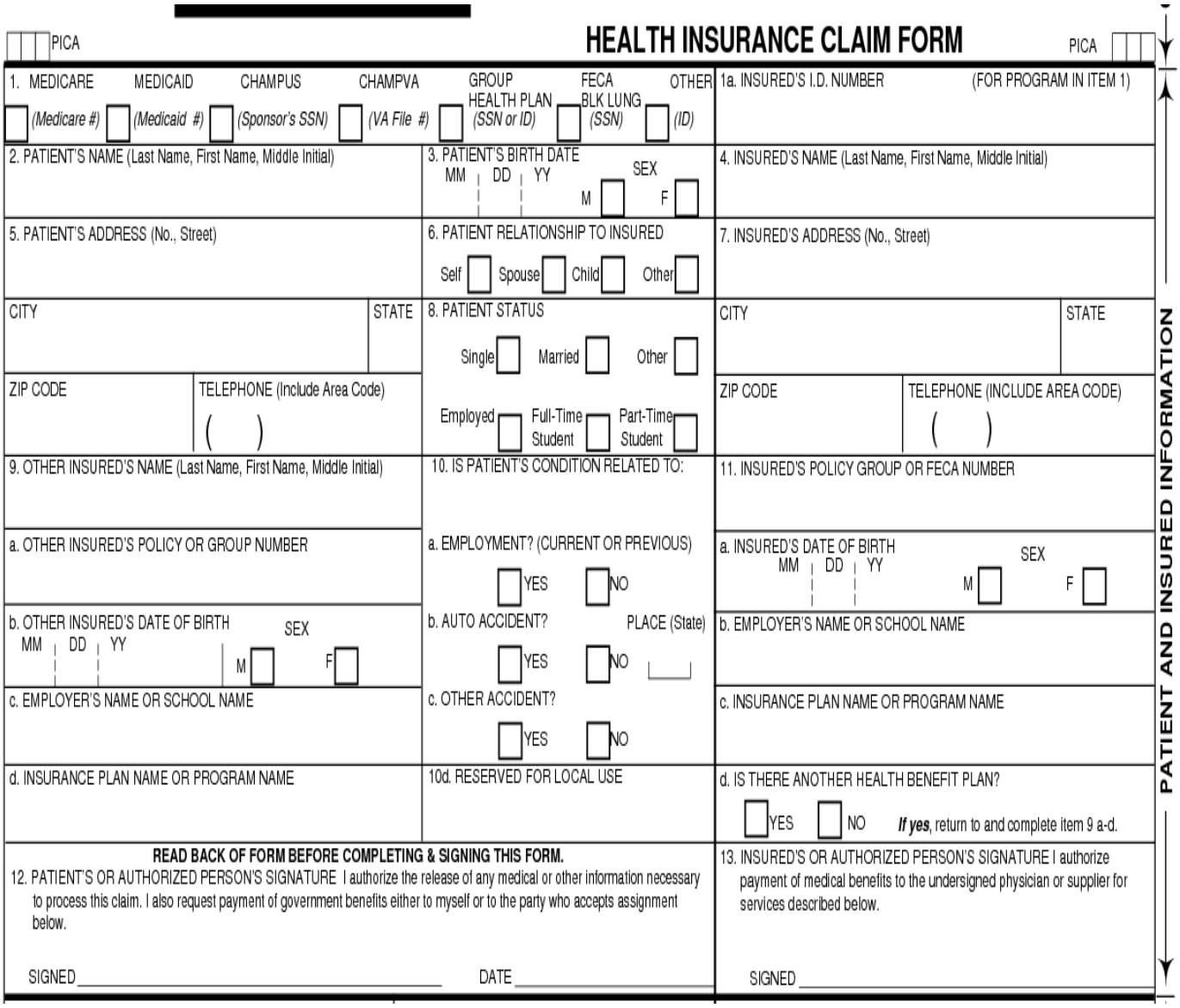
Client _____ Date _____

Therapist _____ Date _____

Credit Card Information – NOTE: YOUR CREDIT CARD INFORMATION IS MAINTAINED ON A DOUBLE SECURE SERVER IN ENCRYTED FORMAT Card number _____Exp Date _____ 3 Digit CCV code___

If you are both the PATIENT and the INSURED PERSON, please complete the INSURED SECTION OF THE FORM BELOW.

If you are the patient and are insured under another person's plan (example, spouse, parent, partner) please complete BOTH THE PATIENT SECTION AND THE INSURED SECTION OFTHE FORM BELOW)



PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION