Scott Kampschaefer, LCSW

176 Thomas Johnson Drive, Suite 204,
Frederick, MD 21702

(Please print clearly)

Date:

Client information		
Name *(First, M.I., Last):*		
Street:		
City:	State:	ZIP Code:
Home #: ( )	Work #: ( )	Cell #: ( )
Social Security # (only if needed for billing) :		
Date of Birth:	Sex: M F Nonbinary	
Marital Status: Single Married Widowed Divorced Legally Separated Partners Minor		
Employment Status: Full-Time Part-Time Retired Non-Employed	If Student: Full-Time Part-Time	
Client Employer:		
Client School (if student):		
Occupation:		
Emergency Contact- Name:	Phone: #	Relation to Ct:
How did you hear about this practice? Circle one Friend / Internet / Insurance Co. / Dr. Referral / Therapist Referral / Other		

Primary Insurance

Subscriber:	Ct. Relationship to Subscriber: Self Spouse Child Other	
Address: (If different from client's)		
Street:		
City:	State:	ZIP Code:
Home #: ( )	Work #: ( )	Cell #: ( )
Subscriber's Social Security #: (only if needed for billing)		
Subscriber's Date of Birth:	Subscriber's Employer:	
Insurance Co. Name:	Policy #:	

Additional Insurance

Is client covered by additional insurance? Yes No		
Subscriber:	Ct. Relationship to Subscriber: Self Spouse Child Other	
Address: (If different from client's)		
Street:		
City:	State:	ZIP Code:
Home #: ( )	Work #: ( )	Cell #: ( )
Subscriber's Social Security #: (only if needed for billing)		
Subscriber's Date of Birth:	Subscriber's Employer:	
Insurance Co. Name:	Policy #:	

Assignment and Release

I certify that I, and / or my dependent(s), have insurance coverage with the above-names insurance company(ies) and assign directly to Scott kampschaefer, LCSW, all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named health care provider may use my health care information and may disclose such information to the above-named insurance coompany(ies) and a billing agent for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Client, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Client, Parent, Guardian or Personal Representative — Relationship to Client