Scott Kampschacfer, LCSW

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

(Please print clearly)	F1	rederick, MD 21702		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 Non	binary			
Marital Status: Single	Married Widowed	Divorced Leg	ally Separated	Partners	Minor
Employment Status: Full-Ti	me Part-Time	Retired	If Student:	Full-Time	Part-Time
Non-Employed					
Client Employer:					
Client School (if student):					
Occupation:					
Emergency Contact- Name:		Phone: #	Re	elation to Ct:	
How did you hear about this prac	tice? Circle one Friend	/ Internet / Insurance (Co. / Dr. Referral	/ Therapist Ref	erral / Other
Buimanu Inaumana					
Primary Insurance Subscriber:		Tot Polationship to Su	haarihari	Self	Spouse
	LI ₂ \	Ct. Relationship to Su	DSCriber.	Child	Other
Address: (If different from client Street:	rs)		Γ	Offilia	Otilei
	State:		ZID Cada		
City: Home #: ()			ZIP Code: Cell #: (1	
, ,	Work #: ()		Cell #. ()	
Subscriber's Social Security #: (only if needed for billing) Subscriber's Date of Birth: Subscriber's Employer:					
Subscriber's Date of Birth:		Policy #:			
Insurance Co. Name:		It office π.			
Additional Incurance					
Additional Insurance Is client covered by additional insurance? Yes No					
Subscriber:		Ct. Relationship to Subscriber: Self Spouse		Spouse	
Address: (If different from client's)		Ot. nelationship to our	DSCHDEL.	Child	Other
Street:					
		ZIP Code:			
City: Home #: ()	Work #: ()		Cell #: (1	
,			Oeii #. (,	
Subscriber's Social Security #: (only if needed for billing) Subscriber's Date of Birth: Subscriber's Employee		r·			
Insurance Co. Name:		Policy #:			
Assignment and Release		i oney ".			
I certify that I, and / or my dependent	dent(s) have insurance	coverage with the abov	e-names insurar	nce company(je	s) and assign
directly to Scott kampschaefer, L					
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.					
payment for services and determ	ining insurance benefits	or the benefits payable	e for related serv	ices.	
Signature of Client,	rsonal Representative		Date		
Please print name of Cli	ent Parent Guardian o	r Parsonal Ranrasantat	ive Rela	ationship to Clie	 ent
riease print name of on	ent, Farent, Guardian o	i Fersonai nepresentat	ive rioic	ationomp to on	ZIII