Kevin S Cameron, LCSW-C
104 Forbes Street, Suite 205 Annapolis, MD 21401
141 Log Canoe Circle, Stevensville, MD 21666
443-833-5980
kscameron57@gmail.com

Insurance Information

Name:_____
First Name, Middle Initial, Last Name

Address:_____
Street, City and State, Zip Code

Preferred Phone Number:_____ Date of Birth:_____

Social Security Number:_____ Marital Status:_____

Name of Spouse, Parent or Guardian:_____

Primary Insurance:_____ Policy #_____

Group #_____ Plan:_____

Policy Holder_____
First Name, Middle Initial, Last Name and Relationship

Policy Holder's Date of Birth_____ Policy Holder SSN:_____

Secondary Insurance:_____ Policy #_____

Group #_____ Plan:_____

Policy Holder_____
First Name, Middle Initial, Last Name and Relationship

Policy Holder's Date of Birth_____ Policy Holder SSN:_____

ASSIGNMENT, RELEASE and HIPAA COMPLIANCE

I hereby assign all medical benefits to which I am entitled to Kevin S Cameron, LCSW-C for services rendered by him. This will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I hereby assume all financial responsibility for all charges whether or not paid by said insurance. I further understand that all balances due are to be paid within 30 days of receipt of statement. I agree to pay 1.5% per month's interest (18%per year) on all accounts unpaid after 30 days. I also acknowledge that this office is HIPAA compliant, that all efforts will be made to ensure my privacy and that all records and copies of HIPAA privacy practices are available to me upon request.

_____ _____
Client or Legal Guardian Signature Date