

Kevin S Cameron, LCSW-C  
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### Ability to Pay

Name: \_\_\_\_\_  
First Name, Middle Initial, Last Name

Fees for Services:

New Client Intake/Evaluation:	\$150.00
50-60 Minute Session:	\$100.00
45 Minute Session:	\$ 75.00
30 Minute Session:	\$ 50.00
Court Appearance:	\$200.00 per hour

I, \_\_\_\_\_, authorize Kevin S Cameron, LCSW-C or designated third party billing agency, holder of my medical information about me, to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. Please note: Co-pay/co-insurance is subject to change at any time. For further co-pay/co-insurance information, please contact your insurance company. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim.

In addition, I, \_\_\_\_\_, understand that it is my responsibility to provide accurate insurance information if I intend to use my insurance coverage. If for any reason my insurance company does not cover or pay for my services within 45 days, I agree to pay for all services rendered.

I also understand that a 24-hour cancellation notification is necessary for canceling or rescheduling an appointment. If 24-hour notification is not given, I understand that I am required to pay a \$50.00 fee for my missed appointment(s). The voicemail system on the business phone operates 24-hours a day.

The only methods of payment currently are cash, check or money order.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Kevin S Cameron, LCSW-C Date