LISA K. SCHKLOVEN, LCSW-C, LLC

3635 OLD COURT ROAD STE 305 PIKESVILLE, MD 21208

PHONE: 443-898-8357 FAX: 443-327-4753

INSURANCE INFORMATION

NAME: _____ **DOB:** _____

PRIMARY INSURANCE/POLICYHOLDER INFORMATION:			
Policyholder's Name:		SSN#	Date of Birth:
Street, City, State, Zip:			
Phone (H)	(W)	(C)	Other
Email:			
Relationship to Policyholder: ☐ Self ☐Spouse ☐ Child ☐ Significant Other ☐ Other			
Insurance Company:			
Street, City, State, Zip:			
Providers Phone #		Consumer's Phone #:	
Group #		Member ID#:	
Authorization #:			
What are your mental health benefits?			
Policyholder's Employer:			
Employer's Street, City, State, Zip:			
SECONDARY INSURANCE/ NFORMATION:			
Do you have secondary insurance? ☐ Yes ☐ No *If you answered yes, please complete the following:*			
Other Insured's Name;			
Other Insured's Policy and/or Group Number:			
Name of Insurance:			
Address:			

CLIENT AUTHORIZATION FORM TO THIRD PARTY PAYERS

I give my authorization to Lisa K. Schkloven, LCSW-C, to use or disclose my protected health information as described below. I give this authorization voluntarily, and authorization will remain in effect until it is revoked in writing.

I authorize Lisa K. Schkloven, LCSW-C to release and furnish, on a confidential and a strict need-to-know basis, any/all protected health information related to services rendered to me that may be necessary now, or in the future to process claims to my insurance company. I hereby authorize payment of medical/mental health benefits due me to Lisa K. Schkloven, LCSW-C. I understand that my insurance company will be billed as a courtesy but that I am responsible for the payment of my account if my insurance does not cover the services rendered to me by Lisa K. Schkloven, LCSW-C.

I further authorize the release, on a confidential and a strict need-to-know basis, of any/all protected health information required by third party payers to facilitate the collection of data for purposes of utilization review, quality assurance, or medical/mental health outcomes evaluation purposes. Such information may be released to insurance companies or other governmental or third-party payers, or any organization contracting with any of the above entities to perform such functions. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

A copy of this authorization and agreement shall be considered as an original for insurance purposes.

Print Name _____

Patient Signature _____ Date _____