



Diana Marinaro, LCSW
Psychotherapist

Insurance Billing Agreement

Name:

I understand that insurance requires my signature to be on file.

I authorize and consent to Diana Marinaro, LCSW to process insurance claims electronically on my behalf and to obtain related information from providers and insurance companies for the purpose of submitting claims and billing for psychotherapy treatment services provided.

By typing my signature below, I agree to be bound by my electronic signature

Signature:

Date: