Diana O'Brien, LCSW, Med
703-930-5498

Client Registration

Client Last Name	First Name	Date of Birth
Home Address	City	State and Zip Code
Occupation	Email Address	Home Phone
Employer	Work Phone	Cell Phone
Spouse, Parent, or Emergency contact	Spouse or Parent Employer	Spouse, Parent, or Emergency Contact Phone

Billing and Insurance Information

Subscribers Name	Primary Insurance Company
Relationship to Patient	ID Number
Subscribers DOB	Group Code
EAP Company	EAP Authorization

Patient Insurance Authorization

I, _____, hereby authorize Diana O'Brien, LCSW, Med, to apply for benefits on my behalf for services rendered. I request payment from _____ Insurance Company or Employee Assistance Program be made directly to Diana O'Brien, LCSW, Med. I certify that the information I have reported with regard to my Insurance coverage is correct and I further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing.

I agree to pay all charges at the time of service and accept legal responsibility for any and all charges for the client named above.

_____ _____

Signature of Subscriber to Beneficiary Date