



1061 El Monte Avenue, Suite B * Mountain View, California 94040 * Office: 650-386-6753 Fax: 650-282-3468

ELECTRONIC PAYMENT AUTHORIZATION

Client Name: _____

Card Holder Name: _____

Card Holder Email/Phone Number: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____

Expiration Date: _____ Security Code (from Back): _____

CO-PAYS/DEDUCTIBLES: Depending on your insurance policy, your insurance carrier may require us to charge co-pays and/or deductibles. These amounts are dictated by your insurance carrier. At the close of each month, we reconcile accounts, and any new co-pay and/or deductible amounts will be charged to your credit card during the first week of the new month.

Initial: _____

NO-SHOW/LATE CANCELLATION: Should you ever need to cancel or reschedule your appointment, please contact us a full 48 hours in advance. Absent 48-hour advanced notice, regardless of the reason for the missed session, (e.g., forgetting, traffic, work or school commitment, sickness) the session fee will be charged to your credit card at the time of billing. Fees for missed appointments cannot be billed to your insurance.

Initial: _____

I authorize Joelle Rabow Maletis LLC, to bill the card listed herein, and understand that this form is valid until the card's expiration or written notice of cancellation.

Signature: _____

Date: _____

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