*1061 El Monte Avenue, Suite B * Mountain View, California 94040*
office: 650-386-6753/fax: 650-282-3468
website: www.joellerabowmaletis.com
email: joellerabowmaletismft@gmail.com

NEW CLIENT/EXAMINEE REGISTRATION FORM

Today's Date (MM/DD/YYYY):

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Birth Date:	Age:	Sex: ☐M / ☐F
Address:					
Social Security Number:		Home Phone Number:		Cell Phone Number:	
Email Address:	Receive our Newsletter: ☐Yes / ☐No	Signature of Patient:			

INSURANCE INFORMATION

Insurance Company: _____

SUBSCRIBER ONLY:

Name: _____

Address: _____

Phone Number: _____

Social Security Number: _____

Date of Birth: _____

Group Number: _____

Policy Number: _____

Client Relationship to Subscriber: _____

We provide insurance submittal as a complementary service to our clients. We accept Tricare, Triwest VA, and the major private carriers (Aetna, Anthem Blue Cross, BlueShield of California, Cigna, United Healthcare). Tricare and Triwest VA are military programs which make payments directly to us. We bill copays/deductibles to the client's credit card. For private carriers, we charge our rate to the client's credit card, and submit claims on behalf of the client to their insurance carrier which, according to the policy, are paid directly to the client.

(Place Insurance Card Here)

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone Number:	Work Phone Number:

My signature below signifies my agreement with the following statements:

The above information is true to the best of my knowledge.
I authorize my insurance benefits be paid directly to Joelle Rabow Maletis, LLC.
I understand that unless otherwise agreed I am financially responsible for any balance.
I authorize Joelle Rabow Maletis, LLC to release any information required to process my claims

Signature of Patient/Legal Guardian _____ Date _____

OFFICE USE ONLY
Therapist: _____
ICDIO Code: _____
CPT Code: _____

Rate/Billing Instructions: