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### NEW CLIENT/EXAMINEE REGISTRATION FORM

<b>Today's Date (MM/DD/YYYY):</b> _____					
<b>PATIENT INFORMATION</b>					
Last Name:	First Name:	Middle Initial:	Birth Date:	Age:	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F
Address: _____					
Social Security Number:		Home Phone Number:		Cell Phone Number:	
Email Address:	Receive our Newsletter: <input type="checkbox"/> Yes / <input type="checkbox"/> No	Signature of Patient: _____			
<b>INSURANCE INFORMATION</b>					
<b>Insurance Company:</b> _____			<p>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.</p>		
<u>SUBSCRIBER ONLY:</u>					
Name: _____					
Address: _____					
Phone Number: _____					
Social Security Number: _____					
Date of Birth: _____					
Group Number: _____					
Policy Number: _____					
Client Relationship to Subscriber: _____					
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative:		Relationship to patient:	Home Phone Number:	Work Phone Number:	
<p>My signature below signifies my agreement with the following statements:</p> <p>The above information is true to the best of my knowledge.</p> <p>I authorize my insurance benefits be paid directly to Joelle Rabow Maletis, LLC.</p> <p>I understand that unless otherwise agreed I am financially responsible for any balance.</p> <p>I authorize Joelle Rabow Maletis, LLC to release any information required to process my claims</p>					
Signature of Patient/Legal Guardian				Date	
_____				_____	

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**OFFICE USE ONLY**

**Therapist:** \_\_\_\_\_

**ICD10 Code:** \_\_\_\_\_

**CPT Code:** \_\_\_\_\_

**Rate/Billing Instructions:**