Dr. Ellen Chazdon, PsyD,LP, LLC

5200 Willson Rd #490

Edina MN 55424

Ph (952) 855-2296

NEW CLIENT FORM

Date:_____ Patient's Full Name:_____

Patient's DOB:_____

Address:_____

Phone#: h:_____cell:_____

E-Mail:_____

Employer/Occupation:_____

Insurance: _____

Insurance ID:_____Group:_____

Policy Holder:_____Policy Holder's DOB_____

Policy Holder's Social Security#:_____

I hereby authorize payment of medical benefits to Ellen Chazdon, PsyD, LP for services rendered to me and/or my dependents.

I hereby authorize the release of any medical information to the insurance company as necessary to process claims (e.g. diagnostic code, dates of service, etc.).

I understand that I am financially responsible to Dr. Chazdon for the charges not covered by my insurance and the benefits quoted are only an estimate, and not a guarantee of payment. If uninsured, I will make payment at the same time services is provided, unless other arrangements are made with Dr. Chazdon. This applies to services provided to myself and/or my dependents.

Client/Parent/Guardian
Signature_____Date:_____