Lifestyle Center for Counseling & Nutrition

2380 Third Street South,Suite 2, Jacksonville Beach, FL 32250
Phone (904) 614-5521 Fax (904) 328-2083
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Date of Interview: _____ Referred by: _____

Patient Name: _____ Gender: __ Male __ Female

Date of Birth: ___/___/_____ Age: ___ SSN _____

Address: _____

City: _____ State:___ Zip Code:_____ School: _____

Home Phone:_____ Can Messages be left there? ___ Yes ___ No

Mobile Phone: _____ Can Messages be left there? ___ Yes ___ No

Work Phone: _____ Can Messages be left there? ___ Yes ___ No

Email Address: _____ Parent/Guardian Name: _____

Treatment Team

Therapist _____ Ph: _____ Fax:_____

Psychiatrist _____ Ph: _____ Fax: _____

Physician _____ Ph: _____ Fax: _____

(address) _____

Goals for Counseling: _____

Goals for Nutrition & Weight: _____

Authorization for Treatment and Billing

My signature below indicates that I have consented to the evaluation and treatment by Lifestyle Center for Counseling & Nutrition. I certify that I understand the financial policies of this provider, and acknowledge that all of my questions, if any, have been answered to my satisfaction. Many Insurance plans are not filed by this provider but I can receive a receipt that can be filed with my claim. This office does not guarantee reimbursement by my insurance company. I understand that I am responsible for all charges including any fees related to collection or legal fees related to this account:

Patient/Parent or Legal Guardian Signature: _____ Date: _____