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 (if applicable) _____

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. Insurance is 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