LBS Nutrition, LLC
192 Summerhill Road, Suite 201
East Brunswick, NJ 08816
732-210-9581

PATIENT INFORMATION & AGREEMENT

Patient Name:_____ DOB _____

Insured name (if different):_____ DOB _____

Street Address: _____

City:_____ State_____ Zip_____

Home Phone:_____ Cell Phone: _____

Email: _____

Primary Care Physician (PCP): _____

Referred by: _____

I, _____, request that authorized insurance benefits are paid on my behalf to LBS Nutrition LLC for services rendered to me. Additionally, I authorize any holder of medical information about me to release it to our office for the rendering of services and the processing of insurance billings.

I certify that all the information provided by me on this form is true and accurate. I have received/reviewed the HIPPA Privacy Notice of this office and hereby guarantee, acknowledge responsibility for, and will assume payment of all charges against this account as they accrue. This includes agreeing to pay the $35 missed appointment fee out of pocket.

Patient Signature:_____ Date: _____