FOR OFFICE USE ONLY:
Authorization # ________________
# of Visits ______________________
Start Date ______________________

INNOVATIVE LIFESTYLE NETWORK, LLC

1801 N. TRYON STREET * SUITE B304 * CHARLOTTE, NC 28206 * OFFICE 704-504-7274 * FAX 704-919-5564

REFERRAL DATE: __________________ **REFERRED BY:** ____

CLIENT NAME: _______________________________________ **CLIENT GENDER:** ________________ **AGE:** ______

DOB: _______________ **SOCIAL SECURITY #:**________________ **ETHNICITY:** _________________________

□ **BIOLOGICIAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN NAME ____

PHONE (_______) ___________________ ALTERNATE PHONE: (_________) _________________________

EMERGENCY CONTACT ____

HOME PHONE (_______) ___________________ WORK HOME (_________) _________________________

ADDRESS ____ CITY:______________ STATE:________ ZIP:__________

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ COMPREHENSIVE ASSESSMENT ☐ FAMILY THERAPY ☐ PARENTING COURSE

☐ GROUP THERAPY ☐ COUPLES THERAPY ☐ ANGER MANAGEMENT COURSE

☐ INDIVIDUAL THERAPY ☐ OTHER:_______________________________________

BRIEF DESCRIPTION OF PROBLEM

(ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

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INSURANCE INFORMATION

PRIMARY INSURANCE ____

NAME OF INSURED __________________________________ POLICY # __________________________________

DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? YES/NO

PLEASE FAX OR SCAN THIS COMPLETED FORM TO (704) 919-5564 OR INFO@INNOVATIVELIFESTYLENETWORK.COM