

Insight Therapeutic Services, LLC  
10979 Reed Hartman Highway, Suite 210  
Cincinnati, OH 45242

**Registration**

Client name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Psychiatrist Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## Insurance Information

Insurance Provider: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's SS#: \_\_\_\_\_

Policy Holder's Birthdate: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Policy Holder's City, State, Zip: \_\_\_\_\_

Client's Relationship to Insured:

Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ I fully understand that I am responsible for payment of services if my insurance company does not cover the cost of services.

\_\_\_\_\_  
Client Signature/Parent or Guardian

Signature (for minor child)

\_\_\_\_\_  
Date