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

Registration

Client name: _____

Address: _____

City:_____State:_____ Zip:_____

Phone: ( ) _____

Email address_____

Pronouns: ____she/her ____he/him ____they/them ____other:

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 Date

Signature (for minor child)