DEEP ROOTS
FAMILY THERAPY

# Deep Roots Family Therapy, LLC
# 2600 N Reynolds Rd Suite 101A
# Toledo, OH 43607

## Registration Form

Hello and welcome! Please take a moment to print and complete the following information and submit it on the website. Please bring your driver's license and any insurance card you plan on using to your first appointment. In the case of rescheduling, kindly give 24 hours notice prior to the time of your appointment.
***Failure to do so or no show will result in a $75 fee.***
Thank you for contacting me, I look forward to meeting with you.

**Patient Information**

Last Name: _____ First Name: _____ M.I.:_____
I prefer to be called: _____ Marital Status: _____ Gender: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ SS#: _____
Best phone number: _____ Email: _____
Occupation: _____ Employer/School: _____
Spouse/Parent/Guardian Name: _____
Emergency Contact Person & Phone Number: _____
Primary Care Physician: _____
Psychiatrist: _____

**Insurance Information**

If you will be using insurance to pay for your therapy, it is your responsibility to clarify your mental/behavioral health coverage with your insurance company. All co-payments, co-insurance/deductible amounts are due at the time of service. These are your out-of-pocket responsibilities before insurance covers services.
Policy Holder Last Name: _____ First Name: _____ M.I.: _____
Date of Birth: _____ Relationship to Patient: _____ Phone #: _____
Insurance Company: _____ ID #: _____ Group #: _____
Address (if different from patient): _____
Employer Name: _____ Phone: _____

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