Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

Mary L. Ossowski, LCSW
Licensed Clinical Social Worker

Lori K. McKenzie, Psy.D.
Licensed Clinical Psychologist

Springfield Psychological Center, LLC

Donald R. Henke, LCSW
Licensed Clinical Social Worker

Bill McKenzie, MA, LCPC
Licensed Clinical Professional Counselor

Jenna Reid Yates, Ph.D.
Licensed Clinical Professional Counselor

Greg Irwin, LPC, ALMFT
Licensed Professional Counselor

DEPENDENT REGISTRATION FORM

PATIENT INFORMATION:

NAME_____

ADDRESS_____CITY_____ZIP_____

SOCIAL SECURITY #_____ DOB _____SEX _____

HOME PHONE_____ PRIMARY CARE PHYSICIAN_____

RESPONSIBLE PARTY INFORMATION:

NAME_____

ADDRESS_____CITY_____ZIP_____

SOCIAL SECURITY #_____RELATIONSHIP_____

WORK PHONE_____ HOME PHONE_____

EMPLOYER_____

INSURANCE INFORMATION:
Primary Coverage
NAME OF INSURED_____ DATE OF BIRTH_____

ADDRESS_____CITY_____ZIP_____

RELATIONSHIP_____ HOME PHONE_____

NAME OF INSURANCE COMPANY_____

POLICY #_____ **GROUP #** _____ **ID #**_____

I will take responsibility for payment of services. I will take full responsibility, if any, due to a third party payment failure, for a carried balance on my account. I give permission for the release of any information necessary for billing my insurance, and, if necessary, the recovery of funds by a collection agency or attorney. If the utilization of a collection agency and/or attorney is needed, I agree to pay the additional fees and costs of a fee of 33.3% of the unpaid balance as an authorized percentage collection fee. I authorize payment of medical/ psychological/social work benefits to the undersigned psychologist/social worker or supplier for services rendered. Person(s) completing this application consent to evaluation and treatment given by this psychology office using commonly accepted outpatient procedures. I understand that I will be billed a $1.00 or 1.5% service charge, whichever is higher for monthly billing if my account is 60 days past due.

_____ _____

DATE **SIGNED**
(Patient/Insured or Authorized Agent)