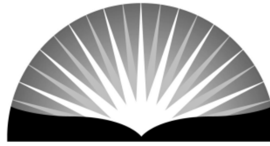
Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

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

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 #_________________________

Secondary Coverage

NAME OF INSURED______________________________ DATE OF BIRTH_______________________

ADDRESS_________________________________CITY______________________ZIP______________

RELATIONSHIP___________________________ HOME PHONE_____________________________

WORK PHONE___________________ 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)

3416 Liberty Drive ● Springfield, IL 62704 ● (217) 793-3949 ● FAX (217) 793-3995