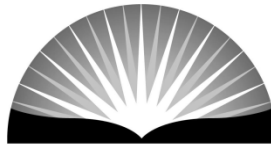


**Michael S. Trieger, Psy.D.**  
Licensed Clinical Psychologist

**Melissa Fisher Paoni, Ph.D.**  
Licensed Clinical Psychologist

**Helen P. Appleton, Ph.D., ABPP**  
Licensed Clinical Psychologist

**Mary L. Ossowski, LCSW**  
Licensed Clinical Social Worker



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

**Donald R. Henke, LCSW**  
Licensed Clinical Social Worker

**Bill McKenzie, MA, LCPC**  
Licensed Clinical Professional Counselor

**Jenna Reid Yates, Ph.D.**

## Springfield Psychological Center, LLC

### REGISTRATION INFORMATION

#### **PATIENT INFORMATION:**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

#### **INSURANCE INFORMATION:**

##### Primary Coverage

NAME OF INSURED \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ 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 full responsibility for payment for services. I will take full responsibility due to any 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)