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

Springfield Psychological Center, LLC

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.

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)