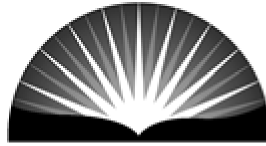
Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

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

Bill McKenzie, MA, LCPC
Licensed Clinical Professional Counselor



Springfield Psychological Center, LLC

Greg Irwin, LCPC
Licensed Clinical Professional Counselor

Jeanette Hoelzer, LCPC
Licensed Clinical Professional Counselor

Bethany Bilyeu, Psy.D.
Licensed Clinical Professional Counselor

Kelsie Tobias, LCSW
Licensed Clinical Social Worker

ADULT REGISTRATION FORM

PATIENT INFORMATION:

NAME: ______________________ DATE OF BIRTH: ______________ Gender: __________

ADDRESS: ______________________ CITY: ____________________ ZIP: __________

PHONE #: ______________ WORK #: ______________ PRIMARY CARE: ______________

INSURANCE INFORMATION:

Primary Coverage

INSURANCE COMPANY: ______________________ EMPLOYER: ____________________

ID#: ______________________ GROUP #: ______________________

NAME OF POLICY HOLDER: ______________________ DATE OF BIRTH: ______________

RELATIONSHIP: ________________ PHONE #: ______________________

ADDRESS: ______________________ CITY: ____________________ ZIP: __________

□ CHECK IF SAME AS LISTED ABOVE

Secondary Coverage

INSURANCE COMPANY: ______________________ EMPLOYER: ____________________

ID#: ______________________ GROUP #: ______________________

NAME OF POLICY HOLDER: ______________________ DATE OF BIRTH: ______________

RELATIONSHIP: ________________ PHONE #: ______________________

ADDRESS: ______________________ CITY: ____________________ ZIP: __________

□ CHECK IF SAME AS LISTED ABOVE

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/Guardian)

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