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# Springfield Psychological Center, LLC

## ADULT REGISTRATION FORM

### PATIENT INFORMATION:

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: M / F

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)