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

CHILD REGISTRATION FORM

PATIENT INFORMATION:

NAME: _____ DOB: _____ Gender: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PRIMARY CARE PHYSICIAN: _____

RESPONSIBLE PARTY INFORMATION:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ ZIP: _____

□ CHECK IF SAME AS LISTED ABOVE

PHONE #: _____

EMPLOYER: _____ WORK #: _____

INSURANCE INFORMATION:

Primary Coverage

INSURANCE COMPANY: _____ EMPLOYER: _____

ID#: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH: _____
(e.g. Parent/Guardian)

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: _____
(e.g. Parent/Guardian)

RELATIONSHIP: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ ZIP: _____

□ CHECK IF SAME AS LISTED ABOVE

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 12+ years)

_____ _____

DATE SIGNED (Parent/Guardian)