CHILDREN'S RESOURCE GROUP

PATIENT INFORMATION FOR MINOR CHILD

Child's Name		Date of Birth	Sex	SS#
Address, City, State, ZIP				
Home Phone	Father's Work Phone	Mother's Work Phone	Emergency Phone	
Father's Name		Mother's Name		
Parents' Address (if different from child's)				
Father's Occupation		Employed By		
Mother's Occupation		Employed By		
Siblings' Names and Ages				
Child's Preschool / Day Care		Grade or Program		
Child's Physician		Physician's Address		

PAYMENT POLICY

The fee is payable in full at the time of service, unless other arrangements have been made prior to the appointment. We do accept MasterCard and VISA as a means of payment.

I have read and understand my financial obligation. I understand that any and all collection fees incurred will also be my responsibility.

______________________________ ______________

Signature Date

CONSENT TO TREAT

I request and authorize Children's Resource Group (hereinafter collectively referred to as "CRG") and their respective agents and employees who may attend me during my treatment to perform routine test and procedures and to provide certain services as prescribed for my health and well-being in accordance with applicable laws and regulations. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by CRG, nor have I relied upon any such representations, warranties, or guarantees.

______________________________ ______________

Legal Guardian Signature Date

State relationship to patient: ______________________________

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of the CRG Patient Admission Packet, which includes but is not limited to the Notice of Privacy Practices ("Notice"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at www.childrensresourcegroup.com.

______________________________ ______________

Legal Guardian Signature Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF INORMATION

I, ____, the undersigned, hereby authorize Children's Resource Group to use or disclose protected health information of the Patient identified below in the manner described in this authorization:

Patient's Name: ______________________________ **Patient's Date of Birth:** _______________

Patient's Address: ____

Children's Resource Group has permission to:

Conduct a developmental assessment on the above mentioned child. I authorize the release of any information acquired in the course of the developmental assessment

To: Park Tudor School

For the purpose of: Sharing relevant information to aid in the admittance process.

I, the undersigned, have read or been informed of the following:

(1) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the Patient's ability to obtain treatment.

(2) I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

(3) I understand that this authorization will expire in one hundred eighty (180) days from the date the authorization is executed, unless revoked by me prior to that date.

(4) I understand that I may revoke this authorization by notifying Children's Resource Group / CRG Associates in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Children's Resource Group in reliance on this authorization.

_________________________________ _______________________________________

Legal Representative Printed Name **Legal Representative Signature**

If Legal Representative, Please Indicate Relationship to Patient: _______________________

_________________________________ _________________________________

Witness **Date**

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