CRG PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: ______________________________ Birth Date: ______________
(Last) (First) (Middle Initial)

Social Security Number: ____________________ Male ______ Female ______

Home Address: ____
(Street / RR Box #) (City/State) (Zip)

Preferred Contact By: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Home Phone: ____________________ Cell Phone: ____________________
(Area Code) (Area Code)

Work Phone: ____________________ Employer: ____________________
(Area Code)

Family Physician: ____________________ Phone: ____________________
(Area Code)

Pharmacy: ____________________ Phone: ____________________
(Area Code)

I give my consent to CRG's providers and/or staff to contact the following person in the event of an emergency:

Emergency Contact: ____________________ Relationship to Patient: ____________________

Home Phone: ____________________ Cell Phone: ____________________
(Area Code) (Area Code)

IF PATIENT IS A MINOR:

Mother's Name: ____________________ Home Phone: ____________________
(Area Code)

Address (if different from patient's): ____
(Street / RR Box #) (City/State) (Zip)

Mother's Employer: ____________________ Mother's Occupation: ____________________

Mother's Work Phone: ____________________ Mother's Cell Phone: ____________________
(Area Code) (Area Code)

Father's Name: ____________________ Home Phone: ____________________
(Area Code)

Address (if different from patient's): ____
(Street / RR Box #) (City/State) (Zip)

Father's Employer: ____________________ Father's Occupation: ____________________

Father's Work Phone: ____________________ Father's Cell Phone: ____________________
(Area Code) (Area Code)

Patient's School: ______________________________ Grade: ______________

Patient's Siblings Names and Ages: ____

PRIMARY INSURANCE

Primary Ins. Co. Name: ______________________ Phone: ______________________

Policy Holder's Employer: ______________________ Effective Date of Coverage: ____________

Policy Holder's Name: ______________________ DOB: ______________________

Policy Holder's Address: ____
(Street/ RR Box#) (City/State) (Zip)

Relationship to patient: ______________________ SSN: ______________________

Policy Holder's ID#: ______________________ Group #: ______________________

Verified Benefits: Yes ☐ No ☐ Authorization Required: Yes ☐ No ☐

**Please contact CRG's billing department at (317) 575-9111 option #9 if you need help obtaining preauthorization.*

BEHAVIORAL HEALTH

Who handles your Behavioral Health (BH) coverage: Primary Insurance Carrier ☐ Separate BH Carrier ☐

**If you answered "Primary Insurance Carrier" you do not need to complete the behavioral health portion of this form.*

Separate BH Carrier: ______________________________

Phone: ______________________ Effective Date of Coverage: ______________________

Policy Holder's Name: ______________________ DOB: ______________________

Policy Holder's Address: ____
(Street/ RR Box#) (City/State) (Zip)

Relationship to patient: ______________________ SSN: ______________________

BH ID#: ______________________ BH Group #: ______________________

Verified Benefits: Yes ☐ No ☐ Authorization Required: Yes ☐ No ☐

******Please contact CRG's billing department at (317) 575-9111 option #9 if you need help obtaining preauthorization.*

CRG does not participate with the following plans. Please indicate if you are covered by one or more as a signed waiver of coverage will be required.		Yes	No		Yes	No
	Medicaid	☐	☐	ICHIA	☐	☐
	Medicare	☐	☐	Tricare	☐	☐

SECONDARY INSURANCE

Please complete ONLY IF your secondary insurance is SAGAMORE:

Policy Holder's Employer: ______________________ Effective Date of Coverage: ____________

Policy Holder's Name: ______________________ DOB: ______________________

Policy Holder's Address: ____
(Street/ RR Box#) (City/State) (Zip)

Relationship to patient: ______________________ SSN: ______________________

Policy Holder's ID#: ______________________ Group #: ______________________

Verified Benefits: Yes ☐ No ☐ Authorization Required: Yes ☐ No ☐

CONSENT TO TREAT

I request and authorize Children's Resource Group/CRG Associates (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.

____ ____________________
Patient Signature or Legal Guardian Signature if patient is a minor Date

If signed by Legal Guardian, 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.

____ ____________________
Patient Signature or Legal Guardian Signature if patient is a minor Date

EMAIL COMMUNICATIONS

CRG recognizes that communication via electronic mail (or "e-mail") between a patient and CRG increases the efficiency in delivering certain non-emergency health care services. CRG is able to handle secure e-mail communications between our patients and our office as of April 17, 2006 after purchasing the encryption software, Tumbleweed.

In order to communicate with our office via email, each family will need to set up an e-mail account with CRG.

***Patient's should never contact CRG via e-mail in an EMERGENCY situation.**

I would like to register for Secure Email services:

Name: ________________________________

Relationship to Patient: ________________________

Email Address: ____________________________

FINANCIAL AGREEMENT & CREDIT CARD AUTHORIZATION

I have received a copy of CRG's Financial Policy, and hereby agree to comply with these requirements. I agree to pay CRG their charges for all services rendered during treatment. I shall also be responsible for any attorney fees required to collect for these services, to which may be added interest at the current legal rate. I hereby assign directly to CRG payment of any health insurance benefits applicable to this treatment and authorize the collection of such funds on my behalf by CRG. Such payments, however, shall not exceed my balance owed to CRG. I acknowledge and understand that I am responsible for all charges not otherwise paid by assignment of insurance benefits. I also acknowledge and understand that CRG will not accept responsibility for negotiating a settlement on any disputed claim. Past due accounts will be transferred to a collection agency and any such accounts will be assessed a thirty-three and one third percent (33.33%) collection fee based upon the balance on the account. I shall be responsible for payment of the balance of my account, plus the thirty-three and one third percent (33.33%) collection fee. I will also be responsible for all costs of collection including reasonable attorneys' fees and expenses. I hereby certify that any information which I have given in applying for coverage under title XVII and/or Title XIX of the Social Security Act, or any insurance or other information which I provided is true and correct.

I authorize CRG to charge the credit card provided below for services rendered, including deductibles and co-pays. This authority expressly authorizes any and all future charges and is to remain in full force and effect until CRG has received a thirty (30) day written notification from the undersigned of any modifications to this credit card authorization. I also agree not to dispute any charges to the credit card after sixty (60) days from the date of the charge.

By signing this Agreement and Authorization, I certify that all information provided below is true and accurate.

Patient Name _______________ DOB _______________

Responsible Party (please print) _______________ Responsible Party's SS# _______________

Relationship to patient _______________ Responsible Party's DOB _______________

Address (Street / RR Box#) (City/State) (Zip) _______________

Home Phone _______________ Work Phone _______________

Credit Card # (*Visa, MasterCard or Discover*) _______________ Expiration Date _______________ V-Code _______________

Please check one: ☐ Debit ☐ Credit ☐ Health Savings Account

Signature of Responsible Party _______________ Date _______________