

# CHILDREN'S RESOURCE GROUP • CRG ASSOCIATES

## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Last) (First) (Middle Initial)

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Please Circle One:    Single            Married            Divorced            Separated            Widowed

Name of Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## IF PATIENT IS A MINOR:

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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: \_\_\_\_\_

Patient's School: \_\_\_\_\_ Grade: \_\_\_\_\_

Patient's Siblings Names and Ages: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Primary Ins. Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
(Street/ RR Box#) (City/State) (Zip)  
Relationship to patient: \_\_\_\_\_ SSN: \_\_\_\_\_  
Policy Holder's ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder's Employer: \_\_\_\_\_ Verified Benefits: Yes No

\*Please indicate if you have coverage  
with the following plans:

	Yes	No		Yes	No
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	ICHIA	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	Tricare	<input type="checkbox"/>	<input type="checkbox"/>

## SECONDARY INSURANCE

Please complete **ONLY IF** your secondary insurance is **SAGAMORE**:

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
(Street/ RR Box#) (City/State) (Zip)  
Relationship to patient: \_\_\_\_\_ SSN: \_\_\_\_\_  
Policy Holder's ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder's Employer: \_\_\_\_\_ Verified Benefits: 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](http://www.childrensresourcegroup.com).

\_\_\_\_\_  
Patient Signature or Legal Guardian Signature if patient is a minor

\_\_\_\_\_  
Date

## 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.

It is the policy of CRG to secure credit card information for services that may be scheduled beyond the initial visit. If you do not wish for the credit card to be charged, it is your responsibility to inform us and arrange for an alternate form of payment at the time of each checkout.

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/Cardholder's Name – (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 or Master Card only)

\_\_\_\_\_  
Expiration Date

For Office Use Only  
Verified By \_\_\_\_\_  
 Debit  Credit

\_\_\_\_\_  
Signature of Responsible Party/Cardholder

\_\_\_\_\_  
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. **Please visit our website at [www.ChildrensResourceGroup.com](http://www.ChildrensResourceGroup.com) to view our E-Mail Policy and establish your account.**

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