

# 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.	Yes	No	Yes	No
Please indicate if you are covered by one or more as a signed waiver of coverage will be required.				
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	ICHIA	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	Tricare	<input type="checkbox"/>

## 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](http://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