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: _____ Work Phone: _____
(Area Code)

IF PATIENT IS A MINOR:

Mother's Name: _____ Home Phone: _____
Biological Mother Step-Mother Legal Guardian Adoptive Mother (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: _____
Biological Father Step-Father Legal Guardian Adoptive Father (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 #7 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 the 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 #7 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	Medicaid	☐	☐	ICHIA	☐	☐
as a signed waiver of coverage will be required.	Medicare	☐	☐	Tricare	☐	☐

SECONDARY INSURANCE

Please complete <u>ONLY IF</u> your secondary insurance is <u>SAGAMORE</u>:

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 (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 between patients and our front office staff can be helpful in many circumstances. By completing this form, I give my consent for CRG to send electronic communications to the email address listed below.

Patient Name _____

Patient DOB _____

Email Address _____

If email address belongs to someone other than the patient:

Name _____

Relationship to Patient _____

MEDICAL PHOTOGRAPHY

I hereby consent to the taking of a photograph of me by CRG. I understand that my photograph may be used to assist with identification and treatment. Other than for treatment and identification reasons, images that identify me will not be released to any outside entity unless requested by me or my legal representative.

_____ _____

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

FINANCIAL AGREEMENT

I have received a copy of CRG's Financial Policy, and hereby agree to comply with these requirements.

_____ _____
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

_____ _____
Signature of Responsible Party Date

A Release of Information may be required if the Responsible Party is someone other than client

CREDIT CARD AUTHORIZATION (OPTIONAL)

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 Authorization, I certify that all information provided below is true and accurate.

_____ _____ _____
Credit Card # Expiration Date V-Code

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

_____ _____
Signature of Cardholder Date

Revised August 17, 2015