CRG PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____ Birth Date: _____
(Last) (First) (Middle)

Social Security Number: _____ Male: _____ Female: _____

Home Address: _____
(Street / RR Box # / Apt. #) (City/State) (Zip)

Preferred Contact Number ***(this number will be used for appointment reminders)***: ☐ Home ☐ Cell ☐ Work

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

Work Phone: _____ Employer: _____
(Area Code) (Ext.)

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: _____

Preferred Contact Number: _____ Preferred Contact: _ Home Cell _ Work

IF PATIENT IS A MINOR:

Parent's Name: _____
Biological Mother/Father Step-Mother/Father Legal Guardian Adoptive Mother/Father

Birth Date: _____ Social Security Number: _____

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

Parent's Employer: _____ Parent's Occupation: _____

Parent's Preferred Contact Number: _____ Preferred Contact: Home Cell Work
(Area Code)

Parent's Name: _____
Biological Mother/Father Step-Mother/Father Legal Guardian Adoptive Mother/Father

Birth Date: _____ Social Security Number: _____

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

Parent's Employer: _____ Parent's Occupation: _____

Parent's Preferred Contact Number: _____ Preferred Contact: Home Cell Work
(Area Code)

PRIMARY INSURANCE

Primary Ins. Co. Name: _____ Ins. Co. Phone: _____

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

Policy Holder's Employer: _____ Effective Date of Coverage: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

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

Relationship to patient: _____ Policy Holder SSN: _____

Verified Benefits: Yes No ~~Aut~~horization 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: _____ BH Carrier Phone: _____

BH ID#: _____ BH Group #: _____

Effective Date of Coverage: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

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

Relationship to patient: _____ Policy Holder SSN: _____

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.*

SECONDARY INSURANCE

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

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

Policy Holder's Employer: _____ Effective Date of Coverage: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

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

Relationship to patient: _____ Policy Holder SSN: _____

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/Parent's Name: _____

Self Biological Mother/Father Step-Mother/Father Legal Guardian Adoptive Mother/Father

Email Address: _____

Parent's Name: _____

Biological Mother/Father Step-Mother/Father Legal Guardian Adoptive Mother/Father

Email Address: _____

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 (REQUIRED)

By signing below, I acknowledge that I have received a copy of CRG's Financial Policy, pages 5 and 6 of the registration packet, and hereby agree to comply with these requirements. Signature on CRG's Financial Agreement is required prior to your appointment.

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.

Depending on how your card is processed, CRG may have the ability to email your receipt. Please include your email address below for your receipt to be emailed if this option becomes available to us.

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

Credit Card # _____ Expiration Date _____ V-Code _____ Cardholder Zip Code _____

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

Cardholder Name _____ Cardholder Signature _____

Cardholder Email Address _____ Date _____

2019 CRG FINANCIAL POLICY
Payment in Full is Required at Time of Service.

CRG accepts payment by cash, check, credit card or money order. As a courtesy to our clients, the responsible party may leave a credit card on file to be automatically run after a service has been provided.

The following are the only exceptions to payment in full at time of service:

- Sagamore or Multiplan* is listed as provider network for your mental/behavioral health insurance benefits (see "Provider Networks" below for more details).
    - ***Beginning 02/01/2019, Multiplan will no longer be a Contracted Provider Network, therefore, payment in full for all Multiplan clients will be required at time of service.**
- Payment arrangements have been made with CRG's billing department at least 24 hours prior to the appointment (see "Payment Arrangements" below for more details).
- Payment arrangements for Psychological Evaluations have been made in advance with the billing department (see our "Evaluations Policy" on the CRG website or obtain a copy at the front office).

Provider Networks

- *Insurance Companies*
    - CRG is ***not contracted*** with insurance companies.
- *Contracted Provider Networks & Providers*
    - CRG is contracted with Sagamore Health Network and Multiplan* to provide a negotiated rate for ***covered*** mental health services.
        - ***Beginning 02/01/2019, Multiplan will no longer be a Contracted Provider Network, therefore, payment in full for all Multiplan clients will be required at time of service.**
        - Not all services provided by CRG are ***covered*** mental health services.
        - It is every client's responsibility to verify their own insurance coverage and understand what is and is not a covered service.
    - Any co-payment amounts and deductibles may be collected at the time of service.
    - The responsible party will be obligated for the remainder of the (billed charge or fee) for all ***covered*** services after 90 days if the (billed charge or fee) has not processed by the insurance carrier.
    - The responsible party will be obligated for the full amount of any ***non-covered*** services at the time the service is provided.
        - It is the responsibility of the client to check benefits with his/her insurance company and understand what is and is not considered a covered service.
- *Non-Contracted Provider Networks, Providers, & Self-Pay Clients*
    - Payment is ***required*** at the time of service for all insurance networks other than those listed above.
- *Medicare, Medicaid, Tri-Care, ICHIA*
    - CRG is not contracted and not able to file insurance claims to Medicare, Medicaid, Tri-Care or ICHIA. Therefore, payment is ***required*** at time of service.
    - The client or legal guardian will be required to sign a waiver documenting their understanding of the above item.
    - Upon request, CRG can provide encounter forms for the client to self-file to one of the above insurance companies.

Filing Claims to Insurance

- The insurance policy is a contract between the insured and the insurance carrier.
- It is the responsibility of the insured person to verify their mental health benefits with their insurance carrier. CRG strongly encourages verifying be done prior to your initial appointment or after there is a change in your insurance.
- ***Failure to provide complete insurance information and a copy of your insurance card may result in patient responsibility for the entire bill.***
- ***Failure to provide new insurance information within 30 days of the effective date of coverage will require you to self-file any prior claims to your new insurance carrier.***

Primary Insurance

- CRG will routinely file insurance claims with a client's primary carrier for services for both contracted provider networks and, as a courtesy, for non-contracted provider networks.
- Pre-authorization or pre-certification requirements by the insurance company are the responsibility of the member and must be put in place prior to the appointment. CRG's billing department will be able to assist with any questions upon request.
- *Important*: In order for CRG to file insurance claims for drug and/or alcohol related services, a separate authorization form must be completed for the insurance carrier and a separate release for parents of minor children. Patients ages 14

and older are required by law to sign the authorization form/release themselves. Please obtain this from the CRG website or from the front office.

Secondary Insurance

- CRG will not file to secondary insurance carriers unless the secondary insurance is one of our contracted provider networks.
- It is the responsibility of the insured to supply to CRG an Explanation of Benefits (EOB) from the primary insurance carrier within 30 days when we are an out of network provider. Failure to supply the EOB's may result in patient responsibility for the entire bill.

Insurance Appeals

- Due to insurance company requirements, filing appeals are the responsibility of the insured.
- CRG will supply documentation requested from the insured to assist with appeals within 72 business hours of the request.

Payment Arrangements

- Payment arrangements will not be accepted for initial visits.
- The responsible party is required to sign a promissory note. This needs to be on file at least 24 hours prior to the appointment.
- The responsible party is required to maintain financial compliance with the terms stated in the promissory note. If financial compliance is not maintained, the account will be turned over to our collection agency.

Outstanding Balances

- Unpaid balances remain the responsibility of the individual who signed the financial agreement on the registration form.
- Account balances due after 60 days from the date of service will prompt the account to be reviewed for collections.
- Once an account has been turned over to our collection agency, the responsible party must resolve the unpaid balances with the agency.
- Financial noncompliance could result in the client receiving a 30-day discharge notice from CRG.
- When the collection agency is engaged on the account, the responsible party will be liable for any interest that may be added at the current legal rate and for any attorney fees required to collect for services.

Missed Appointments and Late Cancellations

- Missed appointments or cancellations made less than 24 hours in advance of the scheduled appointment will be charged to the patient's account at 100% of the fee of the missed appointment.
- After the first missed or late cancelled Intake Appointment, a valid credit card is required to be put on file prior to scheduling the second intake appointment. *Your credit card will not be charged unless the second Intake Appointment is missed or cancelled less than 24 hours of the scheduled appointment.
- Payment in advance will be required to hold an appointment on a provider's schedule after the 2nd late cancelled or missed intake or testing appointment.

Returned Checks

- Checks returned for insufficient funds will result in a $35 charge to the client's account.
- If CRG receives two checks for insufficient funds from the same responsible party, that responsible party will be required to make all future payments by cash, credit card or money order.

Post-Dated Checks

- Post-dated checks will not be accepted.

Minors & Patients with Divorced Parents

- Concerning minor children, the individual bringing the child in will be responsible for payment at the time of service.
- Financially responsible parties who are unable to attend the appointment are encouraged to put a credit card on file so that payment can be collected at time of service. Also, financially responsible parties can call the day of the appointment to make a payment.

Miscellaneous Services and Fees

- CRG is eligible to charge the state-accepted fees for copying records, letter writing, filling out extensive forms, legal services, or other miscellaneous provider services.

Clients will be required to update and sign CRG's Financial Agreement annually