CRG PATIENT REGISTRATION FORM

PATIENT INFORMATION

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

Social Security Number: _____ Sex Assigned at Birth: Male: _____ Female: _____

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

Email Address: _____

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)

IF PATIENT IS A MINOR:

Parent's Name: _____
○ Biological Parent ○ Step Parent ○ Legal Guardian ○ Adoptive Parent

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 Email Address: _____

Parent's Name: _____
○ Biological Parent ○ Step-Parent ○ Legal Guardian ○ Adoptive Parent

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 Email Address: _____

PRIMARY INSURANCE

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

Policy Holder's ID#: _____ Group #: _____ Payer ID/EDI #: _____

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

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 ϒ No ϒ Authorization Required: Yes ϒ No ϒ

**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 ϒ Separate BH Carrier ϒ
**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 ϒ No ϒ Authorization Required: Yes ϒ No ϒ

**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 ϒ No ϒ Authorization Required: Yes ϒ No ϒ

Children's Resource Group (CRG) - Consent & Authorization

1. CONSENT TO TREAT
I request and authorize Children's Resource Group ("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/Legal Guardian Signature: _____ Date: _____

If signed by Legal Guardian, state relationship to patient: _____

2. ACKNOWLEDGMENT OF PRIVACY PRACTICES
I acknowledge receipt of the CRG Patient Admission Packet, including the Notice of Privacy Practices and Non-Discrimination Policy. 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/Legal Guardian Signature: _____ Date: _____

3. EMAIL COMMUNICATION CONSENT
I consent to receive non-urgent email communication from CRG.

Email Address: _____

Signature: _____ Date:_____

4. MEDICAL PHOTOGRAPHY CONSENT
I consent to photographs being taken for identification and treatment purposes only.

Signature: _____ Date: _____

5. EMERGENCY CONTACT
Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

6. NON-COVERED MEDICAID, MEDICARE, and ICHIA SERVICES
I understand CRG is a non-covered/non-contracted Medicaid, Medicare, and ICHIA provider, and is unable to file claims to Medicaid, Medicare, or ICHIA. I understand I will be financially responsible for all services provided by CRG.

Patient Name:_____ Patient DOB:_____

Patient/Legal Guardian Signature: _____ Date:_____

7. NON-AUTHORIZED, NON-PARTICIPATING, NON-CONTRACTED TRICARE SERVICES
I understand CRG is a non-authorized, non-participating, non-contracted Tricare provider, and is unable to file claims to Tricare. I understand I will be financially responsible for all services provided by CRG, and it will be my responsibility to contact Tricare regarding self-filing and benefits. Upon request, CRG can provide encounter forms for self-filing to Tricare.

Patient Name:_____ Patient DOB:_____

Patient/Legal Guardian Signature: _____ Date:_____

FINANCIAL AGREEMENT (REQUIRED)

By signing below, I acknowledge that I have received a copy of CRG's Financial Policy, pages 6 and 7 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)

By checking this box, you agree to opt in to receive electronic statements by email and text. ☐

A Release of Information is required (Page 5) if the Responsible Party or Credit Cardholder listed below is someone other than client or legal guardian.

CREDIT CARD AUTHORIZATION (REQUIRED)

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.

I authorize CRG to email a receipt to the cardholder email address listed below.

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 Address (Street, City, State, Zip)

Cardholder Email Address Date

Children's Resource Group
Authorization for Disclosure of Protected Health Information (PHI)

This is a request for records to be: ☐ SENT ☐ OBTAINED ☐ MUTUAL DISCLOSURE

Please allow thirty (30) business days to process your request for records to be sent or obtained. Copying fees will be charged in accordance with 760 IAC 1-71-3

PATIENT/CLIENT INFORMATION

Name: _____ DOB: _____

Street Address: _____ City/State/Zip: _____

Phone/Fax: _____ Email: _____

RECORDS/INFORMATION TO BE RELEASED TO/OBTAINED FROM:

Person/Organization: _____ Relationship: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

I, the undersigned, hereby authorize Children's Resource Group (CRG) to release and/or exchange with the person/organization designated above the following information concerning me, or the person I represent ***(check all that apply)***:

☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐ All Progress Notes/Appointment Records
☐ Medication History ☐ Lab Results ☐ Substance Abuse Evaluation
☐ Drug/Alcohol Records ☐ Billing & Financials ☐ Other: _____

PURPOSE OF RELEASE: ☐ Coordination of Care ☐ Transfer of Care ☐ Other:_____

I hereby knowingly and voluntarily waive the Indiana law provision that this consent expires in one hundred eighty (180) days. This consent, unless expressly revoked earlier in writing, expires one year from the date below.
Initial: _____

I, the undersigned, have read or been informed of the following:

(1) **I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice.**
(2) **I understand that I have a right to revoke this Authorization at any time, but any such revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Practice expressly for disclosure to the above-listed Person/Entity.**
(3) **I understand that this authorization will expire in one hundred eighty (180) days from the date the authorization is executed, unless waived by me above and/or revoked by me prior to that date.**
(4) **I understand that the PHI disclosed may be subject to re-disclosure by the Person/Entity receiving it and no longer protected by the federal privacy regulations except in the case of drug and alcohol treatment records which must be clearly stamped "Do Not Re-Disclose" and protected accordingly under 42 CFR Part 2.**
(5) **I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact Children's Resource Group at any time.**
(6) **I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling**

_____ _____
Printed Name of Patient **Signature of Patient** (A minor must always sign to release drug and alcohol treatment records, even to a parent or guradian)

_____ _____
Printed Name of Legal Representative **Signature of Legal Representative**

If Legal Representative, Please Indicate Relationship to Patient: _____

_____ _____
Witness **Date**

9106 N. Meridian St. Suite 100
Indianapolis, IN 46260
Phone: 317.575.9111 Fax: 317.571.4470
www.childrensresourcegoup.com

2026 CRG FINANCIAL POLICY
Payment in Full is Required at Time of Service.

CRG accepts payment by cash, check, credit card or money order. The responsible party is required to leave a credit card on file to be automatically processed after a service has been provided. If you do not wish to have your credit card processed automatically, prior arrangements with our billing office must be made.

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

- Sagamore is listed as provider network for your mental/behavioral health insurance benefits (see "Provider Networks" below for more details).
- 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 to provide a negotiated rate for ***covered*** mental health services.
    - 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 Sagamore.
- *Medicare, Medicaid, ICHIA*
  - CRG is not contracted and not able to file insurance claims to Medicare, Medicaid, or ICHIA. Therefore, payment is ***required*** at time of service.
  - By signing item 6 on the Consent Page of the registration packet, you document your 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.
- *Tri-Care*
  - CRG is a non-authorized, non-participating, non-contracted Tri-Care provider and is not able to file insurance claims. Therefore, payment is ***required*** at time of service.
  - By signing item 7 on the Consent Page of the Registration Packet, you document your understanding of the above item.
  - Upon request, CRG can provide encounter forms for the client to self-file to Tri-Care.

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.
    - *CRG will not file claims to **IU Health, MHS, Ambetter, or CareSource**. Upon request, CRG can provide encounter forms for the client to self-file.
  - 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 Sagamore.
- 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