CRH PHYSICIAN PRACTICES, LLC

MINOR PATIENT/ DEPENDENT CHILD REGISTRATION

PATIENT INFORMATION

First Name _____ **Middle Name** _____ **Last Name** _____

Name Preferred _____ **Date of Birth** _____ **SSN#** _____ **Marital Status** _____

Sex ☐ Male ☐ Female **Race** _____ **Ethnicity** ☐ Hispanic ☐ Non-Hispanic **Primary Language** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Secondary Phone** _____

Emergency Contact _____ **Phone** _____

Preferred reminder method: ☐ Phone ☐ E-Mail ☐ Text Message

INSURANCE INFORMATION

We need a copy of your insurance card and Guarantor's Driver's License or Photo ID.

Primary Insurance Carrier Name _____ **Subscriber Phone Number** _____

Policy Number _____ **Subscriber's SSN** _____

Subscriber Name _____ **Subscriber's Date of Birth** _____

Patient's Relationship to Subscriber _____ **Subscriber's Sex** _____

Secondary Insurance Carrier Name _____ **Subscriber Phone Number** _____

Policy Number _____ **Subscriber's SSN** _____

Subscriber Name _____ **Subscriber's Date of Birth** _____

Patient's Relationship to Subscriber _____ **Subscriber's Sex** _____

- **Do you have a third insurance provider?** ☐ Yes ☐ No **If so, please list:** _____

AUTHORIZATION FOR TREATMENT OF A MINOR

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. I authorize the Practice and/or its affiliated companies to render treatment to my minor child without my presence in this office.

✖ _____

Signature **Date**

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GUARANTOR INFORMATION

Note: Guarantor is the person responsible for the bill.

Name _____ **Relationship** _____

Sex ☐ Male ☐ Female **Date of Birth** _____ **Social Security Number** _____

Address _____ **City**_____ **State**_____ **ZIP** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email _____

Employer Name _____ **Work Phone**_____

PLEASE READ & SIGN BELOW

- I authorize my insurance company, Medicare, Medicaid or any Medigap policy to pay benefits on my behalf directly to CRH Physician Practices, LLC. I authorize CRH Physician Practices, LLC to provide my insurance company, the Centers for Medicare and Medicaid Services, its agents or my Medigap insurer any information necessary including my signature to process claims for services rendered to me.
- I understand that if proof of insurance is not available or cannot be verified at the time of service then I am responsible for paying for the services to be rendered. I also understand that it is my responsibility to give all current active insurance information and if information is requested from my insurance company prior to processing a claim that I am responsible for getting that information in a timely manner and keeping the billing office informed of my progress in that process. If I am unable to do so in a timely manner then I understand that I will be responsible for payment of services rendered. Any balance after insurance payment must be paid in full within 90 days of notification from this office unless other payment arrangements have been made in advance.
- I further understand that any sums due me less than $100.00 will be credited to my medical account unless requested. I understand that I am financially responsible for all charges not covered by my insurance assignment.
- Any patient who fails to arrive for a scheduled appointment without cancelling the appointment less than 24 hours prior to the scheduled time is considered a "no-show." A patient who is a "no-show" more than three times may be dismissed from the practice including immediate family members at the discretion of the physician.
- I authorize Coffee Regional Medical Center, CRH Physician Practices, and its service providers to contact me about obtaining potential financial assistance for my accounts(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my accounts(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.
- This authorization is valid unless cancelled in writing. A photocopy is as valid as the original.
- CONSENT AND AUTHORIZATION FOR TREATMENT: I authorize the attending physician and midlevel provider of CRH Physician Practices and any other members of the Medical Staff of Coffee Regional Medical Center who may be consulted by the attending physician or who may be acting in such physician's place to furnish any medical care and treatment including diagnostic procedures which the attending physician and other physicians so authorized deem necessary and appropriate for the Patient's care. It is understood that CRH Physician Practices participates in approved health education programs, which permit students to observe and participate in patient care. The undersigned agrees to allow supervised student participation in his/her care as part of the student's education.

I have read and understand all of the above and have given truthful information to the best of my knowledge.

✖ _____

Signature **Date**

CRH PHYSICIAN PRACTICES, LLC

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AUTHORIZATION FOR SURESCRIPTS

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with **GA** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. CRH PHYSICIAN PRACTICES uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to CRH PHYSICIAN PRACTICES.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to CRH PHYSICIAN PRACTICES
3. I have the right to revoke this authorization at any time by writing to CRH PHYSICIAN PRACTICES. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE CRH PHYSICIAN PRACTICES TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law	Date
✖	
Relationship to Patient	**Interpreter, if utilized**
Witness Signature	

CRH PHYSICIAN PRACTICES, LLC

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Insurance Coverage Waiver

Waiver 1 is to be initialed by patients who have no insurance coverage available at the time of service. Waiver 2 is to be initialed by patients who have Medicaid and no other insurance carrier. Waiver 3 is to be initialed by patients who have insurance (Commercial, Medicare or Medicaid). Waiver 4 is to be initialed by patients who are not covered by Medicaid, Wellcare, Peachstate, Amerigroup or any other government funded healthcare plan- It is possible for patients to have to initial more than one waiver).

1.) I, _____ with a date of birth _____, understand that my eligibility for coverage by _____ (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from CRH Physician Practices. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Patient Initials: _____

2.) I, _____ with a date of birth _____, confirm that I have no other healthcare coverage/insurance except for Medicaid (including Wellcare, Peachstate and Amerigroup). I understand that if Medicaid denies my claim for other insurance coverage that I will be responsible for payment of all services provided.

Patient Initials: _____

3.) I, _____ with a date of birth _____, understand that it is my responsibility to understand my insurance benefits. I understand that if my insurance carrier denies my claim for non-covered or maximum benefits exceeded then I will receive a bill for those services.

Patient Initials: _____

4.) I, _____ with a date of birth _____, confirm that I am not covered by Medicaid, Wellcare, Peachstate, Amerigroup or any other government funded insurance plans at the time of my visit. I will notify the office staff prior to my being seen by the provider if I have or plan on applying for one of these plans. I understand that if I do not notify the office of coverage by one of these plans within three months of my visit, then the office will not file a claim on my behalf and I will be responsible for the balance in full.

Patient Initials: _____

5.) I, _____ with a date of birth _____, understand that CRH Physician Practices is not in network with my insurance plan _____. I understand that I will be responsible for upfront payment of any services rendered and that CRH Physician Practices will not file a claim to my insurance carrier. If other services are rendered during my visit and are not paid in full at the time of service, I understand that I will receive a bill for those services and prompt payment is expected.

Patient Initials: _____

These policies are subject to change without notice. I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable) **Date**

Patient Name (Please Print)