

Childersburg Primary Care

33637 US Highway 280 East  
Childersburg, Al 35044  
256-378-3313  
256-378-3315 Fax

Date \_\_\_\_\_

Chart Number \_\_\_\_\_

Doctor \_\_\_\_\_

Patient Information

Name (last, first, middle initial) \_\_\_\_\_

Address (Inc. appt. numb.) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: M F

- Race:
- White
  - Black/Af. American
  - Asian
  - Indian/Alask.
  - Pac Isle
  - Hawaiian
  - Decline

- Ethnicity:
- Non-Hispanic
  - Hispanic
  - Decline

- Language:
- English
  - Spanish
  - Arabic
  - Bengali
  - Chinese
  - Other \_\_\_\_\_
  - Declined

Referring Physician \_\_\_\_\_

- Marital Status:
- Single
  - Married
  - Widowed
  - Divorced
  - Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Employer Name/Address \_\_\_\_\_

Is your visit work related? \_\_\_\_\_

Guarantor Information

Name (last, first, middle) \_\_\_\_\_

Address (inc. apt. numb.) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: M F

Employer Name and Address \_\_\_\_\_



**CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR  
PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS**

By signing below, you hereby consent for Childersburg Primary Care. (the "Practice") to use or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form. **You should read the Notice of Privacy for PHI, available at the front desk, before signing this Consent.** The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Practice's Privacy Officer for a copy.

You also have the right to request that the Practice restrict how you PHI is used or disclosed in carrying out treatment, payment, or health care operations. Please be aware, however, that the Practice is not required restrictions, though, the restrictions are binding.

Information about you is protected under federal law, and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the Practice has already taken in reliance on your consent (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed may be subject to redisclosure by the recipient and may no longer be protected under federal law.

Childersburg Primary Care may communicate confidential information, including payment invoices, to me at the following address and/ or phone numbers. I understand that I need not supply either, provided I do not wish to be contacted by the Practice.

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_  
\_\_\_\_\_ The Practice may leave a message at this number (Check if yes)

Phone: \_\_\_\_\_  
\_\_\_\_\_ The Practice may leave a message at this number (Check if yes)

I authorize the following persons to communicate on my behalf with the Practice concerning my medical care:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian Date

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY**

\_\_\_\_\_ Acknowledge receiving a copy of Childersburg Primary Care Privacy Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date