Date_____

Update Patient Information

Name (last, first, middle initial) _____

Address (apt. numb.) _____

City, State, Zip Code _____

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

Email Address_____

Date of Birth _____

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

Ethnicity:
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Decline

Language:
- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ Bengali
- ☐ Chinese
- ☐ Other_____
- ☐ Declined

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Other_____

Childersburg Primary Care
33637 US Highway 280 East – PO Box 349
Childersburg, Alabama 35044
256-378-3313 Fax 256-378-3315

Please Read and Sign the Following

Controlled Substance and Pain Medication Prescribing Policy: It is the policy of Childersburg Primary Care to perform drug screenings for any patient who request controlled substances or pain medication. Results will be used to determine appropriateness for such treatments and to determine if the patient is taking illegal drugs and if the patient is taking his prescribed medication as prescribed. Any information received from lab results, state prescribing registries or other sources indicating inappropriate use of medications will result in an immediate dismissal from the practice. Any patient found to be using illegal drugs is subject to dismissal as well.

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants. This treatment may include but is not limited to medications, immunizations, anesthesia, surgical and invasive procedures, lab, x-ray or other studies that may be helpful in the performance of the patient's care.

Authorization for the Release of Medical Record and Insurance Information: I hereby authorize the release of any and all medical record, including psychiatric, drug, alcohol, HIV and substance abuse records and any and all financial accounting records including insurance information to referring physicians or agencies involved in the performance of quality assurance and to other clinic owned and operated by Childersburg Primary Care at which patients seek medical care.

Assignment of Benefits and Guarantee of Account: I acknowledge full financial responsibility for any services rendered to me or my dependents and I understand that the payment of charges incurred in this office are due at the time of service. I also understand the charges not covered by insurance remain my responsibility and assign insurance benefits to this clinic. In the event an account is turned over to a collection agency, I agree to pay all cost of collecting including reasonable attorney fees and hereby waive all rights of exemption under the Constitution of the State of Alabama.

Date: _____ Signed Guarantor_____
Parent_____ Patient _____ Other_____

For Patients Who Can Not Sign

_____ _____
Name of Authorized Representative Relation to Patient

_____
Address

Reason Patient Can Not Sign

Childersburg Primary Care
33637 US Highway 280 East – PO Box 349
Childersburg, Alabama 35044
256-378-3313 Fax 256-378-3315

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 your 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 re-disclosure 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 is 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