Clifton E. Garris, M.D.
Katherine A. Harrison, DNP, NP-C
P: 256-245-6700

MARBLE CITY FAMILY CARE & OBSTETRICS

11 North Norton Ave
Sylacauga, AL 35150
F: 256-245-6002

PLEASE COMPLETE ENTIRE FORM IN PRINT

PATIENT INFORMATION:

Patient Name: Last	First		Middle
Preferred Name	E-Mail Address	Preferred Pharmacy/City	
Date of Birth	Social Security Number		Sex ☐Female ☐Male
Address	City	State	Zip
Home Phone	Cell Phone	Preferred Number ☐Home ☐ Cell	
Emergency Contact Name	Relationship	Phone number	

RACE: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Undetermined	**ETHNICITY:** ☐ Hispanic ☐ Non-Hispanic ☐ More than one race ☐ Undetermined ☐ Unreported	**LANGUAGE:** ☐ English ☐ Spanish **MARITAL STATUS:** ☐ Married ☐ Single ☐ Other

LEGAL GUARDIAN INFORMATION: (FILL OUT ***IF*** PATIENT IS A MINOR)

Mother/Guardian Name		**Father/Guardian Name**	
DOB	SSN	DOB	SSN
Address		Address	
Cell Phone	Work Phone	Cell Phone	Work Phone

INSURANCE INFORMATION:

PRIMARY Insurance Company		**Secondary Insurance Company**	
Policy Holder	Policy Holder's DOB	Policy Holder	Policy Holder's DOB
Contract Number	Group Number	Contract Number	Group Number
Employer		Employer	

MARBLE CITY FAMILY CARE & OBSTETRICS

Consent for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Marble City Family Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Marble City Family Care may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment or healthcare operations of the practice. Marble City Family Care is not required to agree to the restrictions that I request. However, if Marble City Family Care agrees to a restriction that I request, the restriction is binding on Marble City Family Care.

I have the right to revoke this consent, in writing at any time, except to the extent that Marble City Family Care has taken action in reliance on this consent.

My "Protected Health Information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected healthcare information relates to my past, present or future physical or mental health condition and identifies me. Or there is a reasonable basis to believe the information my identify me. I understand that I have the right to review Marble City Family Care's Notice of Privacy Practices prior to signing this document. Marble City Family Care's Notice of Privacy Practices has been provided/offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected healthcare of my protected healthcare information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Marble City Family Care. The Notice of Privacy Practices for Marble City Family Care is also provided in the waiting room. This notice of Privacy Practices also describes my rights and Marble City Family Care's duties with respect to my Protected Healthcare Information.

Marble City Family Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling and requesting a revised copy sent to me in the mail or asking for one at the time of my next appointment.

I authorize payment of medical benefits to be paid to Marble City Family Care for services provided to me. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection. I agree this authorization shall be valid until rescinded in writing.

I hereby authorize release of my medical records from other medical providers to Marble City Family Care.

_____ _____

Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ **Copy Accepted ☐** **Copy Declined ☐**

Date

Staff Signature _____ Date _____