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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	

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MEDICAL HISTORY:

ALLERGIES: ☐ No Allergies

Allergy	Reaction

MEDICATIONS: Please List All (If you need more room please ask for a separate sheet of paper)

Medication	Dose	Times Per Day

PAST SURGICAL HISTORY:

Type (Specify Left or Right)	Date	Location/Facility

SOCIAL HISTORY:

Smoke Cigarettes? **Y** **N**	Drink Alcohol? **Y** **N**
Current: Packs/Day _____ #of Years _____	☐Beer ☐Wine ☐Liquor
Past: Quit Date _____ Packs/Day ____ # of years ____	# of drinks per week _____
☐Vape ☐Pipe ☐Snuff ☐Cigar ☐Chew	Do you use Marijuana or Recreational Drugs? Y N

PERSONAL MEDICAL HISTORY:
(Please detail any medical condition)

FAMILY MEDICAL HISTORY:
(Please list any medical condition and relative)

MARBLE CITY FAMILY CARE & OBSTETRICS

COMMUNICATION CONSENT:

I authorize Marble City Family Care to leave information on my answering machine or voicemail regarding appointment reminders, medications, billing, insurance information, and/or any information pertaining to clinical health services.
YES☐ NO☐

I authorize Marble City Family Care to send me text messages regarding appointment reminders, medications, billing, insurance information, and/or any information pertaining to clinical health services.
YES☐ NO☐

Dr. Garris and Office Staff is permitted to talk to:
It is necessary that we have your permission to speak to anyone regarding your health care. Please list any family members or friends you authorize us to discuss your medical care with.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

CONSENT FOR TREATMENT – I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.
AUTHORIZATION FOR RELEASE OF INFORMATION – I authorize Marble City Family Care and Obstetrics, PC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.
ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to Marble City Family Care and Obstetrics, PC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Marble City Family Care and Obstetrics PC, charges for these services. I understand that I am financially responsible to Marble City Family Care and Obstetrics, PC for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination or benefits.
GUARANTEE OF ACCOUNT – For services furnished by Marble City Family Care and Obstetrics, PC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

_____

Printed Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative

_____

Date

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 _____

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Formulary Benefits Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Marble City Family Care can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

_____	_____
Printed Patient Name	Date of Birth
_____	_____
Signature of Patient or Representative	Relationship if other than patient
_____	_____
Consent Denied	Date

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MEDICAL HISTORY: ADDITIONAL

MEDICATIONS:

Medication	Dose	Times Per Day

PAST SURGICAL HISTORY:

Type (Specify Left or Right)	Date	Location/Facility

PERSONAL MEDICAL HISTORY:
(Please detail any medical condition)

FAMILY MEDICAL HISTORY:
(Please list any medical condition and relative)
