Children's of Alabama

Mayfair Medical Group

Father's Name: _____ Date of Birth: _____

Please check- Race: ___ American Indian/Alaska Native ___Blk/African American ___ Nat Hawaiian/Pacific Islander ___Asian ___White ___Other ___Declined

Please check- Ethnicity: ___Declined ___Hispanic/Latino ___Not Hispanic/Latino ___Unknown

Primary Language: _____ **Email address:** _____

Mailing Address: _____ City _____ State_____ Zip_____

Home Phone # ( ) _____ Cell Phone # ( ) _____ Work Phone # ( )_____

Employer _____ Address _____

Mother's Name: _____ Date of Birth: _____

Please check- Race: ___American Indian/Alaska Native ___Blk/African American ___ Nat Hawaiian/Pacific Islander ___Asian ___White ___Other ___Declined

Please check- Ethnicity: ___Declined ___Hispanic/Latino ___Not Hispanic/Latino ___Unknown

Primary Language: _____ **Email address:** _____

Mailing Address: _____ City _____ State_____ Zip_____

Home Phone # ( ) _____ Cell Phone # ( ) _____ Work Phone # ( )_____

Employer _____ Address _____

Primary Insurance _____ owner of policy _____

Policy Number _____ Group Number _____

Effective date _____ Co-Pay _____

Secondary Insurance_____ owner of policy _____

Policy Number _____ Group Number _____

Effective date _____ Co-Pay _____

Emergency Contact: _____ Relationship to patient (s) _____

Phone # ( ) _____ Cell Phone # ( ) _____ Work Phone # ( )_____

List patients (in this family) to be seen by us:

Primary Physician (circle one): Habeeb Doyle Gilbert Peters McCain Russell Fettig Mizerany

Name _____ _____ M F Birth Date_____

Name _____ _____ M F Birth Date_____

Name _____ _____ M F Birth Date_____

PLEASE READ THE FOLLOWING VERY CAREFULLY

Consent for treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants.

Authorization for release of medical records and insurance information: I hereby authorize the release of any or all medical records including psychiatric, drug alcohol, substance abuse and any and all financial and accounting records, including insurance information to referring physicians or agencies from whom the patient seeks medical care.

Assignment of benefits and guarantee of account: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all cost of collection including attorney's fees; all court cost if any and a $25.00 collection fee.

Consent to contact for information/reminders: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Mayfair Medical Group to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Divorced Parents: In keeping with our policy that payment is due at the time service is rendered, it is the person who brings the patient to us who is responsible for payment and who should sign as responsible party.

Date: _____ **Responsible Party's Signature** _____