

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 8-20-15 Are you an AUM student? ☒ YES ☐ NO Student ID # S002344109

Name: Aliyah Simmons

Social Security Number: 416-47-1748 Birth Date 01/17/97

Local Phone Number: _____ Alternate Number: _____

Local Address: North Commons 208-A Box Number _____

City: Montgomery State: _____ Zip Code: _____

Permanent Address: 6103 Fawnhurst Dr.

City: ANNISTON State: Alabama Zip Code: 36206

Marital Status (Please Circle): ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: DR. RAY City: ANNISTON Phone #: _____

Patient's Employer: _____ Work #: _____

Parent's or Spouse's Name (Circle which) JANICE SIMMONS Phone #: (256) 820-7462

Parent's or Spouse's Employer: UPS Work #: _____

Emergency Contact: Sholanda Scott Relationship: SISTER Phone #: 256-454-3701

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☒ Orientation ☐ Other _____

INSURANCE INFORMATION

Do you have health insurance? ☒ YES ☐ NO

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

Insurance Company BCBS Name on Card SIMMONS, JANICE

Policy Number TEA806081330 Group Number P13168

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Aliyah Simmons Date of Birth 01 / 17 / 97

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Aliyah Simmons
Signature of Patient

08 / 20 / 15
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

AUM Student Health Services PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 20 day of August 2015.

Print Patient Name Aliyah Simmons

Signature Aliyah Simmons

Relationship to Patient _____

*AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)*

Name: Aliyah Simmons Date of Birth: 01 / 17 / 97

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call ☒ my home ☒ my work ☐ my cell Number: 256-870-7462

If unable to reach me:

☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: Aliyah Simmons Date: 8 / 20 / 15