

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 6.18.2019 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: William A. Beringer "Will" Birthdate: 11.28.03

Main Phone Number: 334.538.6548 Email: lydiabp@yahoo.com

Local Mailing Address: 3149 Hathaway Place Box or APT #: _____

City: Montgomery State: AL Zip Code: 36111

Permanent/Home Address: 3149 Hathaway Place Box or APT #: _____

City: Montgomery State: AL Zip Code: 36111

Marital Status: Single ☒ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Sex: Male ☒ Female ☐ Gender: Male ☒ Female ☐

Primary Physician: Dr. Diebel City: Montgomery Phone #: 334.272.1799

Patient's Employer: student Work Phone #: _____

Parent's ☒ Spouse's Name: ☐ Lydia & Michael Beringer Phone #: 334.538.6548

Parent's or Spouse's Employer: Warren Averett Phone #: 334.260.7333

Emergency Contact: Marlene Beringer Relationship: grandmother Phone #: 334.399.6868

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 front desk in order for a copy to be made for your chart.

Insurance Company: BCBS Name on Card: Michael Beringer

Policy or Contract Number: WAA816008800 Group Number: 57978

Insurance Company's Address: 450 Riverchase Parkway East
Bham, AL 35244

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Will Beringer Date of Birth: 11 / 28 / 03
Day Month Year

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 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.

Will Beringer

Signature of Patient

6 / 18 / 19
Day Month Year

Date of Signature

Sydie Beringer

Signature of Legal Representative (if patient is unable to sign)

mother

Relationship to Patient

AUM Student Health Services
Medical Information Release
Form (HIPPA Release Form)

Name: Will Beringer Date of Birth 11/28/03
2003

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: Michael Beringer
☐ 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: (334)-538-6548

If unable to reach me:

- ☒ you may leave me a detailed message
☐ please leave a message asking me to return your call
☐ other: _____

The best time to reach me is (day or days) anytime between _____ and _____ times.

Signed: Lydi P Beringer
Date: 6/18/2019

AUM Student Health Services

PATIENT HIPPAA 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 (HIPPA). 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 involve 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 HIPPA. 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 with 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 18th day of June 20 19.
(day) (month) (last two digits of the year)

Print Patient's Name: Will A. Beringer

Signature: Will Beringer

Relationship to Patient (if you are the patient, write "self"): mother

AUM Student Health Services - Travel Health History

Date: 6/18/19 Name: Will A. Beringer

1. What is the reason for your visit today? typhoid vaccine
2. List allergies you have to medicines, foods or iodine: _____

3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): advil, allergy & congestion

4. Have you had any of the following? (Check if this applies to you):
Heart Disease ☐ Stomach/Gastrointestinal Disease ☐
Kidney Disease ☐ Diabetes/Sugar ☐
5. Are you immunocomprised? (Is there a problem with your immune system)
Yes ☐ No ☒
Thymus Disorder (Myasthenia gravis, Thymoma, Thymectomy) ☐
Spleen removed ☐ Transplant recipient ☐
Cirrhosis of the liver ☐ Cancer ☐ HIV ☐
6. How often do you drink beer, wine, wine cooler or liquor?
Never ☒ Rarely ☐
1-2 times a week ☐ 3-4 times a week ☐ 5 or more times a week ☐
7. Where are you going on your trip? Costa Rica, Belize
8. How long is your trip? Months _____ Days 14 days
9. When are you leaving on your trip? June 27, 2019

For Females Only

- A. Date of your last period? _____ Have you had a hysterectomy? Yes ☐ No ☐
- B. Are you currently pregnant? Yes ☐ No ☐ Due date: _____
- C. Do you plan to become pregnant in the next 3 months? Yes ☐ No ☐
- D. Are you breastfeeding? Yes ☐ No ☐