

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

amccoll10@aum.edu

Date: 10/8/2013 Are you an AUM student? ☒ YES ☐ NO Student ID # 173405

Name: Ashlea McCollough

Social Security Number: 418 41 2759 Birth Date May 13, 1993

Local Phone Number: 256 453 9104 Alternate Number: 256 449 9244

Local Address: 303 North Ross Street Box Number Apt 115

City: Arbun State: Az Zip Code: 36830

Permanent Address: 456 Co. Rd. 112

City: Woodland State: Az Zip Code: 36280

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: Books A Million-TigerTown Work #: 334 741 8554

☒ Parent's or Spouse's Name (Circle which) Rebecca Rainwater Phone #: 770 846 4275

Parent's or Spouse's Employer: Family Dollar Work #: 256 357 0574

Emergency Contact: Rebecca Rainwater Relationship: Mother Phone #: 770 846 4275

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Julia McLaughlin

DATE: 11/18/13

SIGNATURE: Julia McLaughlin

DATE: 11/20/13

SIGNATURE: Julia McLaughlin

DATE: 12-3-13

SIGNATURE: Julia McLaughlin

DATE: 12-15-14

SIGNATURE: Julia McLaughlin

DATE: 12-17-14

SIGNATURE: _____

DATE: _____

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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 15 day of December 2014.

Print Patient Name

Ashelea McElroy

Signature

Ashelea McElroy

Relationship to Patient

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

Name: Ashlea McElroy Date of Birth: 05 / 13 / 93

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: 256 453 9104

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) any between (time) any

Signed: Ashlea McElroy Date: 12 / 15 / 14



ASHLEA M MCCOLLOUGH

Identification Number
SOP893A15563-04

Benefits Effective as of:

01/01/2010

OV/SP QV 25/50

DED CAL YR 250
COINS% IN/OUT 90/70

Group No/Name:
THE SOUTHERN COMPANY

BYO0730001

BlueChoice PPO



bcbsga.com

Possession of this card does not guarantee eligibility of benefits.

Providers: File all claims to your local Blue Cross Blue Shield Plan with the 3-character alpha prefix that precedes the member ID on the front of the card.

Pre Certification: YOU are responsible for obtaining pre certification for all hospital admissions and certain outpatient procedures. Failure to pre certify may reduce your benefits.

Members: Please refer to your benefits literature for a detailed explanation of your benefits.

Member Services	1-866-758-2105
24/7 NurseLine	1-888-724-BLUE
Pre Certification	1-800-722-6614
Caremark Pharmacy*	1-800-843-5670
ValueOptions MH/SA* (For all except GPC & SAV)	1-800-680-6333
Cameron & Associates MH/SA* (For GPC & SAV)	1-800-334-6014
*Not a Blue Cross Blue Shield product	

Blue Cross and Blue Shield of Georgia, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

120509



ASHLEA M MCCOLLOUGH

Identification Number
URYAN3228696

Group:	006000016	Office Visit	\$25
Plan Codes:	834/332	Emergency Room	\$50
		Preventive Care	\$0

Issue Date: 12/10/2012



anthem.com

Providers: If Medicare is primary,
pre certification is not required.

Member Services	1-877-271-2904
Pre Certification	1-877-453-5639
Coverage While Traveling	1-800-810-2583
Caremark Pharmacy	1-800-843-5670
Cameron & Associates MH/SA*	1-800-334-6014

Please file medical claims with the Blue
Cross and Blue Shield plan in the state
where the services are rendered.
If Medicare is primary, file claims to
Medicare.

View provider listings, benefits, claims,
and health and wellness information
24 hours a day 7 days a week by
visiting anthem.com.

Possession of this card does not
guarantee eligibility for benefits.

*Contracts directly with group

Anthem Blue Cross and Blue Shield is the trade name of Blue
Cross and Blue Shield of Georgia, Inc., an independent
licensee of the Blue Cross and Blue Shield Association, and
provides administrative claims payment services only and
does not assume any financial risk or obligation with respect
to claims.