

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 8/14/19 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Cristyn Baker Birthdate: 03/21/1982

Main Phone Number: 334-300-7825 Email: cj0321@live.com

Local Mailing Address: 4365 Hillside Oaks Box or APT #: _____

City: Montgomery State: AL Zip Code: 36109

Permanent/Home Address: _____ Box or APT #: _____

City: _____ State: _____ Zip Code: _____

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

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

Primary Physician: Dr. Chai Chamnong City: Montgomery Phone #: 239-8939

Patient's Employer: Adams Drugs Work Phone #: 277-4800

Parent's ☐ Spouse's Name: ☒ Jonathan Robertson Phone #: 652-1622

Parent's or Spouse's Employer: The Home Depot Phone #: 260-8702

Emergency Contact: Chris Baker Relationship: Father Phone #: 324-9727

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: Cristyn Baker

Policy or Contract Number: PPA818369847 Group Number: 25890

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

AUM Student Health Services

Medical Information Release

Form (HIPPA Release Form)

Name: Cristyn Braker Date of Birth 3/21/1982

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: Jonathan Robertson

☐ 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)-300-7825

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: Cristyn Braker

Date: 8/14/19

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 14th day of August 20 19.
(day) (month) (last two digits of the year)

Print Patient's Name: Cristyn Bruker

Signature: Cristyn Bruker

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

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Cristyn Parker Date of Birth: 03 / 21 / 1982
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.

Cristyn Parker
Signature of Patient

8 / 14 / 19
Day Month Year
Date of Signature

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

Relationship to Patient

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Cristyn Baker
DATE OF BIRTH 03/21/1982
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Cristyn Boul DATE 8/14/19
FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you?

yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

immunization
action coalition



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (4/18)

AUM Student Health Services - Travel Health History

Date: 8/14/19 Name: Cristyn Baker

1. What is the reason for your visit today? Vaccines
2. List allergies you have to medicines, foods or iodine: N/A
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Yasmen, Lexapro, Klonopin
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? Kenya
8. How long is your trip? Months _____ Days 11-12 days
9. When are you leaving on your trip? November 1, 2019

For Females Only

- A. Date of your last period? N/A 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 ☒



BlueCross BlueShield
of Alabama

BLUE CROSS
**PREFERRED
CARE**

Subscriber Name

CRISTYN NICOLE BAKER

Contract Number

PPA818369847

Group Number **25890**

Effective Date **01-01-2014**

Rx BIN Number **004915**

HEALTH

PAC



CHUBB

Questions?
800.964.7096

Member

Montgomery Drug Company, Inc.

Policy/Cert#: MDXN14288053

Name: CHRISTYN BAKER

Member ID: GAPB000456780

Effective: 07.01.2018

Medical Plan

Inpatient Benefit.
\$4,000 Per Ind
Per Plan Year
\$12,000 Fam Max
Per Plan Year

Outpatient Benefit.
\$2,400 Per Ind
Per Plan Year
\$7,200 Fam Max
Per Plan Year



www.bcbsal.com

Providers file claims and direct questions about claim payments to the local Blue Cross and/or Blue Shield Plan.

Member Customer Service: 1 800 292-8868
PPO Provider Locator: 1 800 810-2583
Preadmission Certification: 1 800 248-2342
Provider Benefits/Eligibility: 1 800 517-6425
Pharmacist: 1 800 216-9920

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
An Independent Licensee of the
Blue Cross and Blue Shield Association.

10C003-003

Claims Submission

EDI Payor ID # 22384
Mail: Administrative Concepts, Inc.
994 Old Eagle School Road, Ste 1005
Wayne, PA 19087-1802

www.visit-aci.com 800.964.7096

Provider Must Include:
*Itemized Bill or HCFA Form
*Primary Carrier EOB

Underwritten by:
ACE American Insurance Company

Utilization

Pays up to a selected maximum benefit per person per benefit year for hospital confinement or outpatient treatment due to an injury or sickness that begins after the Effective Date. Plan requires that the Insured Person's Major Medical/Comprehensive Policy covers the expense.

Additional Plan Info

Customer Service 800.964.7096
Benefits may be limited to the deductible, co-payment or co-insurance amount the Insured is required to pay under their Major Medical/Comprehensive Policy, subject to the provisions, limitations, and exclusions of the policy.

THIS IS NOT MAJOR MEDICAL INSURANCE