

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 6-7-2017 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Karrington Leigh McTier

Social Security Number: _____ Birth Date Jan. 14, 2000

Local Phone Number: 334-281-0607 (Home) Alternate Number: 334-233-4893 cell

Local Address: 5930 Blackstone Drive Box Number _____

City: Montgomery State: Alabama Zip Code: 36116

Permanent Address: Same as above

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): ☐ Male ☒ Female

Primary Physician: Dr. Susan Brannon City: Montg. AL Phone #: 272-1799
334-277-1776

Patient's Employer: _____ Work #: _____

Parent's or Spouse's Name (Circle which) Sunya Terry Phone #: 334-233-4893

Parent's or Spouse's Employer: Auburn University Work #: 334-213-5012

Emergency Contact: Tonya Terry Relationship: Aunt Phone #: 334-294-5097

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 _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Karrington L. McTier Date of Birth 01 / 14 / 00

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.

Karrington McTier

Signature of Patient

7 / 7 / 17
Date of Signature

[Signature]
Signature of Legal Representative (if patient unable to sign)

Mother
Relationship to Patient

Auburn Montgomery Student Health Services

PATIENT HIPPA 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 Auburn Montgomery Student Health Services (AUSHS) 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 health care operations of AMSHS practice.

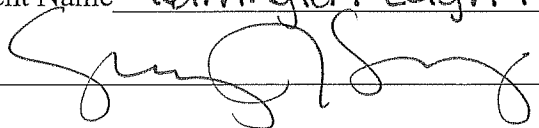
I have also been informed of and given a copy of AMSHS *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that AMSHS reserves the right to change the terms of this from time to time and that I may contact AMSHS 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 AMSHS is not required to agree to these requested restrictions. However, if AMSHS does agree, they 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 7th day of June 20 17.

Print Patient Name Karrington Leigh McTier

Signature 

Relationship to Patient Mother

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

Name: Karrington Leigh McTier Date of Birth 01/14/00

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: Dr. Susan Brannon, mother

☐ 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)-233-4893

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) Monday - Friday between 8:00 am and 5:00 pm times.

Signed: _____

Date: 06/07/17

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 6-7-2017 Name Karrington Leigh McTear

1. What is the reason for your visit today get shots for trip
2. List allergies you have to medicines, foods or iodine: none known
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): none
4. Have you had any of the following: (circle if this applies to you);
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (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? (Please circle)
(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? Quito Ecuador
8. How long is your trip? Months _____ Days 9 days
9. When are you leaving on your trip? June 16th / next week

FOR FEMALES ONLY

- A. Date of your last period? June 2 Have you had a hysterectomy? YES _____ NO ✓
- B. Are you currently pregnant? YES _____ NO ✓
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO ✓
- D. Are you breastfeeding? YES _____ NO ✓