



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Patient Information UPDATE Form

Are you an AUM Faculty or Staff member? ☒ Yes ☐ No Are you an AUM Student? ☐ Yes ☐ No
If yes, please select the semester you are currently enrolled: ☐ Fall ☐ Spring ☐ Summer

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 10/4/22 Student Number: _____ Birthdate: 2-5-73
Last Name: Parsons First Name: Scott Preferred: _____
Phone Number: 334-740-9584 Email: sparsons@aum.edu
Local Mailing Address: 2023 Ellen St Box or APT#: _____
City: MGM State: AL Country: MGM Zip Code: 36106
Primary Physician: _____ City: _____ State: _____ Phone Number: _____
Emergency Contact: Madelyn Parsons Relationship: DAUGHTER Phone Number: 334-705-9362

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.

Primary Insurance Company: BCBS Policy or Contract Number: QA0820557862
Group number: 37655 Name on Insurance Card: Scott W Parsons
Relationship: — Policy Holder Date of Birth: 2-5-73
Policy Holder's Employer: AUM Phone Number: _____

MEDICAL HISTORY

Do you have any new allergies or medical conditions?

NO

Please list any medications you are currently taking:

~~TRAZADONE~~ TRAZADONE

FLUOXINE

Preferred Pharmacy and Phone Number: _____

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 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 HIPAA 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 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.

General Consent for Treatment

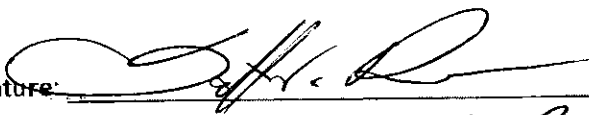
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

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.

Signature:  Date: 10 / 4 / 22
Print Patient's Name: Scott W. Presons
Relationship to Patient (if you are the patient, write "self"): SELF

Warhawk Health Services
Medical Information Release Form (HIPAA Release Form)

Name: SCOTT PARSONS Date of Birth 2/5/73

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:

Name: Dr. ASOLADE Phone: _____ Relationship: PSYCH

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ 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)-740-9584

If unable to reach me:

☒ Please send me an email

☐ Please leave me a message to return your call

☐ Please leave me a detailed message

☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☒ Anytime

Signature: _____

Date: 2/4/22