

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 2/10/20 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: CAROL Sue Reeves Birthdate: 8/27/1948

Main Phone Number: 334-207-7702 Email: CSUE@KNOWLOGY.NET

Local Mailing Address: 8113 Ansley Trace Box or APT #: _____

City: MONTGOMERY State: AL Zip Code: 36117

Permanent/Home Address: SAME AS ABOVE Box or APT #: _____

City: _____ State: _____ Zip Code: _____

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

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

Primary Physician: DR. KATHY LINDSEY City: MONTGOMERY Phone #: 334-213-3606

Patient's Employer: Retired Work Phone #: _____

Parent's ☐ Spouse's Name: ☐ N/A Phone #: _____

Parent's or Spouse's Employer: _____ Phone #: _____

Emergency Contact: PEGGY LOWERY Relationship: SISTER Phone #: 334-224-0896

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: UNITED HEALTH CARE MED. ADV. Name on Card: CAROL S. REEVES

Policy or Contract Number: 911-87726-04 Group Number: 15502

Insurance Company's Address: P.O. BOX 30995, SALT LAKE CITY, UTAH 84130-0995

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Carol Sue Reeves Date of Birth: 8 / 27 / 1948
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.

Carol Sue Reeves
Signature of Patient

8 / 2 / 2020
Day Month Year
Date of Signature

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

Relationship to Patient

AUM Student Health Services

Medical Information Release

Form (HIPPA Release Form)

Name: Carol Sue Reeves Date of Birth 8/27/1948

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: Peggy Lowery - sister

☐ 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)-207-7702

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) any day between any time and _____ times.

Signed: Carol Sue Reeves

Date: 2/8/2020

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

Name: _____ Date of Birth: _____

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 for:

☐ 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 (____) - (____) - _____

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) _____ between _____ and _____ times.

Signed: _____
Date: _____

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 8th day of February 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: CAROL Sue Reeves

Signature: Carol Sue Reeves

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

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 involve in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
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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 _____ day of _____, 20____
(month) (day) (last two digits of the year)

Print Patient's Name: _____

Signature: _____

Relationship to Patient (if you are the patient write "Self"): _____

AUM Student Health Services - Travel Health History

Date: 2/10/2020 Name: Carol Sue Reeves

1. What is the reason for your visit today? fvL. VACCINATIONS to go to Cali, Colombia
2. List allergies you have to medicines, foods or iodine: pneumonia vaccine;
demerol & morphine make me sick; don't like versed
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Restasis, Flonase, multivits, Lexapro,
miralax, Zyrtec, Zocor, Synthroid, Vit D, Protin (6 mos), Xanax (prn)
4. Have you had any of the following? (Check if this applies to you):
- Heart Disease ☒ mitral valve prolapse
murmur
premature heart beat Stomach/Gastrointestinal Disease ☐
- Kidney Disease ☐ Diabetes/Sugar ☒ hypoglycemia
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 ☒ skin cancer
twice HIV ☐
6. How often do you drink beer, wine, wine cooler or liquor?
- Never ☐ Rarely ☐
- 1-2 times a week ☒ MO 3-4 times a week ☐ 5 or more times a week ☐
7. Where are you going on your trip? Cali, Colombia
8. How long is your trip? Months — Days 8 days
9. When are you leaving on your trip? March 14, 2020

For Females Only

- A. Date of your last period? 1989 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 ☒

AUM Student Health Services - Travel Health History

Date: _____ Name: _____

1. What is the reason for your visit today? _____
2. List allergies you have to medicines, foods or toxins: _____
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): _____

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 immunocompromised? (a there's 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? _____
8. How long is your trip? Months _____ Days _____
9. When are you leaving on your trip? _____

For Females Only

- A. Date of your last period? _____ Have you had a hysterectomy? Yes ☐ No ☐
- B. Are you currently pregnant? Yes ☐ No ☐ One date: _____
- C. Do you plan to become pregnant in the next 6 months? Yes ☐ No ☐
- D. Are you breastfeeding? Yes ☐ No ☐