

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 02/11/2020 Are you an AUM Student? ☐ Yes ☒ No S-Number: 421-27-3974
Name: Phillip George Neighbors Birthdate: 05/01/1976
Main Phone Number: 334-467-3448 Email: wildturkeyridge@gmail.com
Local Mailing Address: 845 Brookwood Dr. Box or APT #: _____
City: Wetumpka State: AL Zip Code: 36093
Permanent/Home Address: Same Box or APT #: Same
City: Same State: Same Zip Code: Same
Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other: _____
Sex: Male ☒ Female ☐ Gender: Male ☒ Female ☐
Primary Physician: Jean Crepault City: Montgomery Phone #: 334-271-5700
Patient's Employer: Coosa County Hwy Department Work Phone #: 256-377-2261
Parent's ☐ Spouse's Name: ☒ Lynsey Neighbors Phone #: 334-467-0347
Parent's or Spouse's Employer: Central Alabama Veterans Health Phone #: 334-272-4670
Emergency Contact: Lynsey Neighbors Relationship: Wife Phone #: 334-467-0347
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: Blue Cross Blue Shield Name on Card: Phillip G. Neighbors
Policy or Contract Number: LGB901417034 Group Number: 30000
Insurance Company's Address: 450 Riverchase Parkway East
Birmingham, AL 35244

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: _____ Date of Birth: ____/____/____
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.

Signature of Patient

____/____/____
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: Phillip G. Neighbors Date of Birth 05/01/76

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: Lynsey Neighbors

☐ Child(ren): _____

☒ Other: Mother (Sandra Neighbors)

☐ 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)-467-3448

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: Phillip G. Neighbors

Date: 02/11/2020

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 11th day of February 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Phillip B. Neighbors

Signature: Phillip B. Neighbors

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