

PATIENT INFORMATION (PLEASE PRINT)

Date: 6/4/15 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Betsey Johns

Social Security Number: 42013 0658 Birth Date 12/18/70

Local Phone Number: 334 211 0596 Alternate Number: 334 220 6933

Local Address: 140 Briar Lane Box Number _____

City: Pike Rd State: AL Zip Code: 36064

Permanent Address: Same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Champong City: Montg. Phone #: _____

Patient's Employer: N/A Work #: _____

Parent's or ☒ Spouse's Name (Circle which) Jonathan Phone #: 334 354 2152

Parent's or Spouse's Employer: Normant Security Work #: 334 286 4239

Emergency Contact: Jonathan Relationship: Husband Phone #: 334 354 2152

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 _____

SERVICES CONSENT FORM

NAME: Betsy Johns
DATE OF BIRTH: 12/18/70

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Betsy Johns
DATE: 12/4/15

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

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 involved 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 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 to 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 4th day of June 2015.

Print Patient Name Betsy Johns

Signature Betsy Johns

Relationship to Patient Self

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

Name: Betsey Johns Date of Birth: 12/18/70

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 Johns

☐ 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: 334 220 6933

If unable to reach me:

☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) anytime between (time) _____

Signed: Betsey Johns Date: 6/4/15