



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

**Patient Information Update Form
(Please Print Legibly)**

Date: 8/5/2020 Are you an AUM Student? Yes ☐ No ☒ Student Number: N/A

Name: Zoe D. York Preferred: Zoe Birthdate: 02/12/03

Phone Number: 334/302/11005 Email: zoe.york@gmail.com

Local Mailing Address: 6002 Bell Gables Box or APT#: _____

City: Montgomery State: AL Zip Code: 36174

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

Primary Physician: Dr. Trumbell City: Montgomery Phone #: 334-273-9700

Emergency Contact: Yolanda York Relationship: Mother Phone#: 334-203-346

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: BAPS of Alabama Name of Policy Holder: David York

Policy or Contract Number: HY080 4936888 Group Number: 48984

Insurance Company's Address: 490 Riverchase Parkway East, Birmingham, AL 35244
Policy Holder DOB: 2/25/74

Medical History

Do you have any **new** allergies, medical conditions, or procedures: (Include hospitalization, illnesses, and surgeries)

NIA

Are you taking any medications regularly at the present time (including allergy injections, antidepressants, contraceptives, over-the-counter drugs, etc.)? Yes ☐ No ☒

If yes, please list _____

Preferred Pharmacy and Phone number: _____

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

Name: Zoe York Date of Birth 02/12/03

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: Mother, Yolanda York

☐ 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)-366-21005

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) everyday between all times and all times times.

Signed: Zoe York

Date: 08/05/2008

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Zoe York Date of Birth: 02 / 02 / 2003
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.

Zoe York
Signature of Patient

02 / 02 / 2003
Day Month Year
Date of Signature

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

Relationship to Patient

See Back of Form

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)
- 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.

Signed this 5th day of August 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Zoe You

Signature: Zoe You

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



BlueCross BlueShield
of Alabama



BLUE CROSS
**PREFERRED
CARE**

An Independent Licensee of the Blue Cross and Blue Shield Association.

DAVID YORK

Contract Number

HYN804936888

Effective Date

01-01-2007

Group Number

48584

BS Plan BC Plan

510 010

HEALTH DENTAL VISION

PAC

HYUNDAI

- Medical providers file claims to the Blue Cross and/or Blue Shield Plan serving the area where the services are rendered. All other claims (including member filed) should be sent to Blue Cross and Blue Shield of Alabama at 450 Riverchase Parkway East, Birmingham, AL 35244-2858.
- For Preadmission Certification call 1 800 248-2342 or 205 988-2245 in Birmingham.
- Providers outside Alabama call your local Blue Cross and/or Blue Shield Plan for claim payment information and call 1 800 517-6425 for verification of benefits and eligibility.
- Members call 1 800 810-2583 for information about the nearest PPO provider.

CUSTOMER SERVICE
1 800 292-8868

All Blue Cross and Blue Shield Plans are Independent Licensees of the Blue Cross and Blue Shield Association.
ENR-407 (Rev. 6-2004)