



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Patient Information Update Form
(Please Print Legibly)

Date: 1-5-21 Are you an AUM Student? Yes ☐ No ☒ Student Number: _____

Name: JEFF MCFARLAND Preferred: _____ Birthdate: 5-9-65

Phone Number: 334-303-2626 Email: tree.jeffmc@gmail.com

Local Mailing Address: 9140 CASTLE PINES CIR Box or APT#: _____

City: Mtce State: AL Zip Code: 36117

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

Primary Physician: DANIEL MOORE City: Montgomery Phone #: _____

Emergency Contact: TRUAY MCFARLAND Relationship: WIFE Phone#: 313-2530

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: _____ Name of Policy Holder: _____

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

Medical History

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

NONE

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 Warhawk Health Services

Medical Information Release

Form (HIPAA Release Form)

Name: Jeff E. McFarland Date of Birth 5/2/65

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: Treay McFarland
☐ 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) - 303 - 2624

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: 1/5/21

AUM Warhawk Health Services

CONSENT FOR SERVICES FORM

Patient Name: JEFF McFARLAND

Date of Birth: 5 / 7 / 65
Day Month Year

General Consent for Treatment

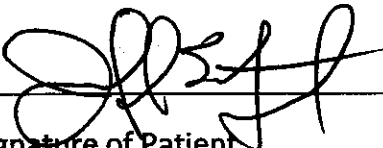
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

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

1 / 5 / 21
Day Month Year
Date of Signature

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

Relationship to Patient

AUM Warhawk Health Services

CONSENT FOR SERVICES FORM

Patient Name: _____ **Date of Birth:** ____/____/____
Day Month Year

General Consent for Treatment

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Signature of Patient

____/____/____
Day Month Year
Date of Signature

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

Relationship to Patient

AUM Warhawk 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 JANUARY 20 21.
(day) (month) (last two digits of the year)

Print Patient's Name: JEFF MCFARLAND

Signature: [Signature]

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